

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death if performed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed together in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15549						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			MAY 23 1985							0945M			
1. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
M			BLK		11 25 92			92								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Snow Hill			USA						Wicomico							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (UP TO 15 CHARACTERS. FIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury			Peninsula General Hospital			LABORER			PAINTER			21863				
13a. STATE Md			13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 103 MASON St.							
14. FATHER'S NAME FIRST ALBERT MIDDLE ALLEN LAST			15. MOTHER'S MAIDEN NAME FIRST ELLEN MIDDLE DENNIS LAST													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213-22-9840			17. INFORMANT Dorothy Allen			ADDRESS Add. same as above			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio respiratory arrest													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)													
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
21a. DATE OF OPERATION Acute Renal Fail			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED and Severe Psychological Vascular Disease			21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			5/23 1985			to 5/23 1985			that (I) (we) last viewed the body after death.							
22b. SIGNATURE Bentley S. Lewis			DEGREE									IN DATE SIGNED 5/23/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-27-85			23c. NAME OF CEMETERY OR CREMATORIAL Emanuel UM			23d. LOCATION CITY OR TOWN Snow Hill Worc, Md							
24. FUNERAL DIRECTOR NAME Jolley Mem. Chapel			ADDRESS Rt #2 Salisbury			25a. DATE REC'D. BY REGISTRAR MAY 28 1985			25b. REGISTRAR'S SIGNATURE Randall							

210212

2

158066

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 7 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 5 6 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR	
Sheldon Oliver Allison						May 26, 1985				0220 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	Black	Apr 3 1967	18 yrs.			May 26, 1985				0220 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Jamaica							Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital			Student						
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8707 Arliss St. # 304	20901				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Lloyd Allison				Joyce Stanford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT Joyce Allison (Mother) same as #13		ADDRESS				
No											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) Depressed Skull Fracture and Fractured 1 hr											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Cervical Spine											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Multiple Trauma											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 01 20 May 26, 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) one vehicle accident						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway			21f. LOCATION STREET Rt. U.S.50 and Walston CITY OR TOWN County STATE Wicomico Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Thomas C. Hill Jr.		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			DATE SIGNED 5/26/85						
Thomas C. Hill Jr.		Pine Bluff Rd., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		5-30-85		Gate of Heaven Cem		Silver Spring, Montg., Md.					
24. FUNERAL DIRECTOR NAME		246 N. Washington St. George R. Snowden Rockville, Md. 20850			25a. DATE REC'D. BY REGISTRAR JUN 03 1985		25b. REGISTRAR'S SIGNATURE John Davidson Pendell				
BP											
DHMH - 17 (VR A15 ME (5))											
20M 4/B2											

an old  
one



**HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

~~148093~~

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 5 5

REG. NO

1. DECEASED NAME (TYPE OR PRINT)			Roy Lee Anderson			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
3. SEX Male			4. RACE BIK			5. DATE OF BIRTH MONTH DAY YEAR Nov. 8 33			6. AGE (IN YEARS LAST BIRTHDAY) 51			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tampa Fla.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE Md.			13b. COUNTY Wicomico			13c. CITY OR TOWN Fruitland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME THOMAS			15. MOTHER'S MAIDEN NAME Anaabelle						13e. STREET ADDRESS, ZIP CODE ALLEN-CUT-OFF Rd 21826 P.O. Box 783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 424-40-9884			17. INFORMANT			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & Cardiac arrest											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b) Hepato-renal syndrome												
DUE TO, OR AS A CONSEQUENCE OF (c) Laennec Cirrhosis.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Cardiomyopathy, Hypertension, GB disease.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>85</u> , to <u>5/14</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/14/85</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) <u>view</u> the body after death.											22c. DATE SIGNED <u>5/14/85</u>	
22b. SIGNATURE <u>Hagan</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME, TITLE			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-18-85			23c. NAME OF CEMETERY OR CREMATORIAL St. James Holiness			23d. LOCATION CITY OR TOWN Snow Hill			STATE MD
24. FUNERAL DIRECTOR AME Josley Mem. Chapel			DR. #2			25a. DATE REC'D. BY REGISTRAR MAY 23 1985			25b. REGISTRAR'S SIGNATURE <u>Glen Davidson - Pendleton</u>			

George

136013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-1. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 5 5 2

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	7b. HOUR		
George		William		BAKER	<input type="checkbox"/>	5-7-85			0420		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				7d. HOUR		
Male	Cauc	02 27 19	66						0420		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Wicomico			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital			retired mechanic-oil			21862			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Maryland		Worcester	Showell	Box 9							
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Charles			Baker	Katherine Lewis Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes		WWII			Teddy L. Baker, Willards, MD 21874			Rt. 1, Box 165			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary emphysema.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										<input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE	
Burial		5/10/85	Pittsville Cemetery			Pittsville			Wicomico	MD	
24. FUNERAL DIRECTOR NAME		ADDRESS									
		Burbage Funeral Home, Berlin, Md.									
		25a. DATE REC'D. BY REGISTRAR									
		25b. REGISTRAR'S SIGNATURE									
		MAY 14 1985 Julia Burbridge									

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

X 10

137034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed with the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other nonnatural event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15553			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1c. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		Barnes			BARNES		MAY 10 1985		1453 M	
3 SEX			4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 23 yrs. HOURS MIN.		
Male			White		07 19 1918			66 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Midland, Michigan			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.						
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA GENERAL MEDICAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Co.			12b. KIND OF BUSINESS OR INDUSTRY Engineer						
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 206 N. Saratoga Street 21801					
14. FATHER'S NAME Carl			MIDDLE Erwin		LAST Barnes		15. MOTHER'S MAIDEN NAME Eurena			LAST Coon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 371-05-0346			17. INFORMANT Mrs. Norma J. Barnes (Wife) Same as #13e			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Cardiomegaly</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma lung</u>															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-10 1985</u> to <u>5-10 1985</u> , that (I) (we) last saw the deceased alive on <u>5-10 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.															
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>5/10/85</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. L. RAFFETTO</u>			22e. ADDRESS <u>PG H</u>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/13/1985			23c. NAME OF CEMETERY OR CRÉMATORIUM Wicomico Memorial Pk			
24. FUNERAL DIRECTOR NAME <u>Holloway Funeral Home, P.A., Salisbury, Md.</u>			25a. ADDRESS ADDRESS			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland			25b. DATE REC'D. BY REGISTRAR MAY 14 1985			25c. REGISTRAR'S SIGNATURE <u>Jane Dawson Pendle</u>			

66  
67



Franklin D. Roosevelt  
President of the United States

Franklin D. Roosevelt  
President of the United States



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										15554			
										REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Rossie BIRKETT						May 4, 1985			1450	
2. SEX			3. RACE			4. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY) 64			# UNDER 1 YEAR MONTHS DAYS	
M			BIRK			March 6 1920						# UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH W1 comico			MD.	
Hebron			USA										
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY Retired			21850	
13a. STATE Md			13b. COUNTY Wicomico			13c. CITY OR TOWN Hebron			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Chestnut Tree Rd	
14. FATHER'S NAME FIRST Unknown			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Amelia A.			LAST Morris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. Korean 212-10-2676			17. INFORMANT Nettie Nutter			ADDRESS Box 245 Hebron Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Cancer lung -</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary embolism</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION 5-3-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy + TUBE Throare			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Ben W. Gaskin</i>													
22c. DEGREE 70 ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nevins W. 1000 Jr.			22e. ADDRESS Suite #25 Hwy Con Wgo Spurshng			22f. DATE SIGNED 5-4-85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-11-85			23c. NAME OF CEMETERY OR CREMATORIUM SPRINGHILL Memory			23d. LOCATION GARDEN CITY OR TOWN			23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel SALISBURY			ADDRESS Rt #2			25a. DATE REC'D. BY REGISTRAR MAY 9 1985			25b. REGISTRAR'S SIGNATURE <i>John Pendell</i>				

2000 ft. - 1000 ft. - 500 ft.

1000 ft. - 500 ft. - 200 ft.

500 ft. - 200 ft. - 100 ft.

200 ft. - 100 ft. - 50 ft.

100 ft. - 50 ft. - 25 ft.

50 ft. - 25 ft. - 12.5 ft.

25 ft. - 12.5 ft. - 6.25 ft.

12.5 ft. - 6.25 ft. - 3.125 ft.

6.25 ft. - 3.125 ft. - 1.5625 ft.

3.125 ft. - 1.5625 ft. - 0.78125 ft.

1.5625 ft. - 0.78125 ft. - 0.390625 ft.

0.78125 ft. - 0.390625 ft. - 0.1953125 ft.

0.390625 ft. - 0.1953125 ft. - 0.09765625 ft.

0.1953125 ft. - 0.09765625 ft. - 0.048828125 ft.

0.09765625 ft. - 0.048828125 ft. - 0.0244140625 ft.

0.048828125 ft. - 0.0244140625 ft. - 0.01220703125 ft.

0.0244140625 ft. - 0.01220703125 ft. - 0.006103515625 ft.

0.01220703125 ft. - 0.006103515625 ft. - 0.0030517578125 ft.

149019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15555

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>George</b>	MIDDLE <b>Washington</b>	LAST <b>Boles</b> <b>BOLES</b>	2a. DATE OF DEATH    MONTH    DAY    YEAR    2b. HOUR				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH    DAY    YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS    DAYS    HOURS    MIN.	
<b>Male</b>			<b>White</b>		<b>02 22 1924</b>		<b>61</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Glen Mills, Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Powellville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Box 7 Mt. Hermon Rd. 21852</b>	
14. FATHER'S NAME FIRST <b>Benjamin</b>			MIDDLE <b>Franklin</b>		LAST <b>Boles</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b>		MIDDLE <b>Unknown</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWII</b>		16c. SOCIAL SECURITY NO. <b>219-14-4659</b>		17. INFORMANT FIRST <b>Mr. Ronald F. Boles (Son)</b>		ADDRESS <b>P.O. Box 108 Pittsville, Md. 21852</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					<i>Cardiogenic shock</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)		<i>Severe MI</i>					
			(c)		<i>ASCD</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>1</i>			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>5/11/85</i> to <i>5/20/85</i> , that (I) (we) last saw the deceased alive on <i>5/10/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Raffetto</i>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/20/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Raffetto</i>			22e. ADDRESS <i>PG H</i>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Powellville Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Powellville</b> COUNTY <b>Wicomico</b> STATE <b>Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/24/1985</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Powellville Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Powellville</b> COUNTY <b>Wicomico</b> STATE <b>Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home, P.A., Salisbury, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 24 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Holloway Funeral Home, P.A., Salisbury, Md.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2100A

1955A

1955A 1955A

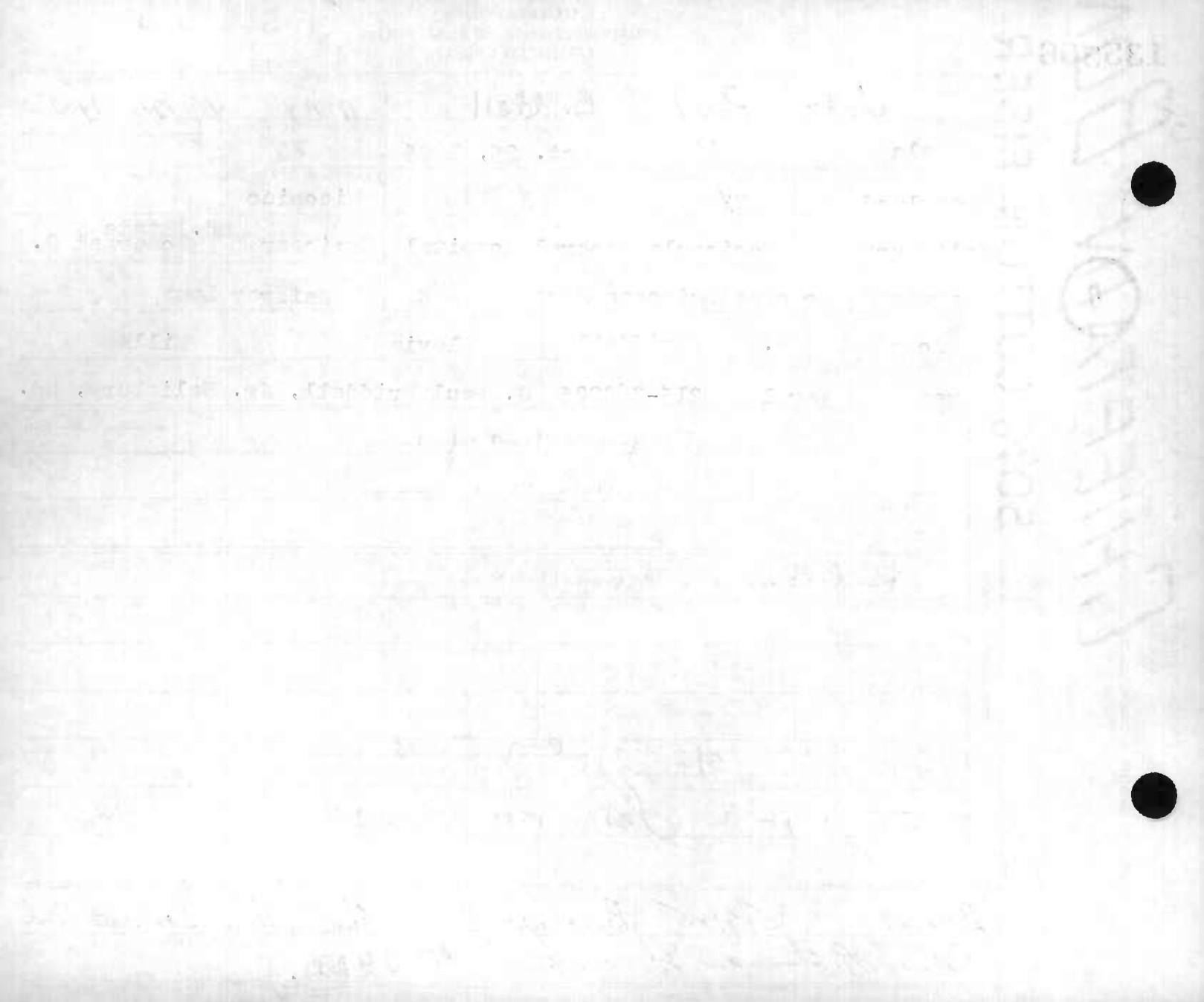
135506

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15556			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST						
<i>John Paul Briddell</i>													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. DATE RECD. BY REGISTRAR MAY 09 1985		8. IF UNDER 1 YEAR MONTHS DAYS		9. IF UNDER 24 HRS. HOURS MIN.	
Male		White		Oct. 25, 1895									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>		10. USUAL OCCUPATION <i>Engineer</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Somerset Co.</i>			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Jeffrey Lane 21853</i>		12a. USUAL OCCUPATION <i>Md.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Somerset Co.</i>			
14. FATHER'S NAME FIRST <i>John</i>		MIDDLE <i>W.</i>		LAST <i>Bridgell</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Olevia</i>		16. SOCIAL SECURITY NO. <i>215-360225</i>		17. INFORMANT ADDRESS <i>J. Paul Bridgell, Jr. Salisbury, Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>War 1</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. DATE OF OPERATION		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		22c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22e. SIGNATURE <i>Joyce L. Sader</i>		22f. DEGREE <i>MD.</i>		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22h. DATE SIGNED <i>5/4/85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/7/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Beechwood</i>		23d. LOCATION CITY OR TOWN <i>Baltimore</i>		23e. COUNTY <i>Somerset</i>					
24. FUNERAL DIRECTOR <i>James L. Neenan</i>		24b. DATE RECD. BY REGISTRAR <i>MAY 09 1985</i>		24c. REGISTRAR'S SIGNATURE <i>J. Paul Bridgell, Jr.</i>									



133596

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1. RETAIN PAGE 5 FOR YOURSELF.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE HELD WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE   5 5 5 / MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	□ MONTH	DAY	YEAR	2b. HOUR		
DONALD			Lee			BRUMLEY						<input checked="" type="checkbox"/>	JULY	5	4	1985	1600	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE KNOWN OF ESTI- MATED	10. MONTH	11. DAY	12. YEAR	13. HOUR								
MALE	WHITE	10 1 52	32 yrs.	MONTHS	DAYS	HOURS	MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. DATE PRONONCED DEAD			10. BALTIMORE CITY OR COUNTY OF DEATH							
Salisbury, Maryland		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			5 4 1985			Wicomico							
11. ID CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
FRUITLAND			212 HAYWARD AVENUE						None			21836						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13c. CITY OR TOWN						
13a. STATE Maryland			13b. COUNTY Wicomico			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 212 Hayward Avenue			14. FATHER'S NAME FIRST MIDDLE LAST						
Howard			Lee			Brumley						15. MOTHER'S MAIDEN NAME Mildred Francis			LAST Chambers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT Mr. Howard L. Brumley (Father) Same as #13e			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:						
No			220-76-3787									IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			(b) SEIZURE DISORDER DUE TO, OR AS A CONSEQUENCE OF							Approximate Interval Between Onset and Death Minutes								
(c)														Years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																		
MENTAL RETARDATION																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>John T. Bulkeley</i> M.D. DEPUTY MEDICAL EXAMINER												TITLE (SPECIFY)						
EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.												DATE SIGNED 5-5-85						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5/8/1985			23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens			23d. LOCATION CITY OR TOWN Hebron, Wicomico, Maryland			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland												25a. DATE REC'D. BY REGISTRAR MAY 9 1985		25b. REGISTRAR'S SIGNATURE <i>Lilia Davidson Pendleton</i>				

202401

CCD 96 A 2 A

S081 20 A 201

OUTLINE

DATA SHEET

DATA

DATA

DATA ENTRANCE

DATA

DATA ENTRANCE

DATA

DATA ENTRANCE

DATA ENTRANCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be given to the funeral director. Then please remove carbon paper. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15558		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	May 18 1985 2334 PM						
Carolyn Jane Campbell												
3 SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 09 DAY 15 YEAR 1940		6 AGE (IN YEARS LAST BIRTHDAY) 44			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.		
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL MEDICAL CTR.							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		
13a STATE Maryland			13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 1506 Rose Drive 21801		
14 FATHER'S NAME John Wesley			MIDDLE	LAST	15 MOTHER'S MAIDEN NAME Charlotte		MIDDLE			LAST Tarr		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 216-38-8027		17 INFORMANT Mr. William Campbell (Husband) Same as #13e		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Allergies to penicillin</i> <i>Cerebral Debris</i> 4511 DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION <i>1/29</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>By fall</i>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>12/29/84</i> , 19 <i>84</i> , to <i>1/1/85</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>12/29/84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			22b. SIGNATURE <i>Benito S. Chan, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>1/29/85</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Benito S. Chan, M.D.			22e ADDRESS 547-D Riverside Dr., Salisbury, Md. 21801									
23a BURIAL, CREMATION, REMOVAL (SPEC#) Burial			23b. DATE 5/22/1985		23c NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens Hebron, Wicomico, Maryland		23d LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR MAY 21 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>							
BP _____			ADDRESS									
DHMH - 16 60M 7/84 (VRA 15, 4)												

WOODEN

COULD BE A FOLKLORE



YAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If item 21 is marked as shown by initial, or other traumatic event, the medical examiner should be notified.

155142

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15559

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Irvin</i>	MIDDLE <i>G.</i>	LAST <i>Catlin</i>	2a. DATE OF DEATH	MONTH <i>5</i>	DAY <i>28</i>	YEAR <i>85</i>	2b. HOUR <i>7 30 M</i>	
3. SEX <i>Male</i>			4. RACE <i>CAUC</i>		5. DATE OF BIRTH MONTH <i>11</i> DAY <i>25</i> YEAR <i>1911</i>	6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 24 HRS MONTHS <i>YRS</i>	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Whitehaven, Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>					
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN THIS FACILITY GIVE STREET ADDRESS <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farming</i>						
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>	13c. CITY OR TOWN <i>Mardela Springs</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route #1 Box 4 21837					
14. FATHER'S NAME FIRST <i>Glen</i>			MIDDLE <i></i>	LAST <i>Catlin</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Laura</i>	MIDDLE <i></i>	LAST <i>Harris</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-12-1657</i>		17. INFORMANT ADDRESS <i>Mrs. Beatrice Catlin (Wife) Route #1 Box 4 Mardela Springs, Maryland 21837</i>						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Congestive Heart Failure</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio Sclerotic Cardiovascular Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from <i>5/25</i> , 19 <i>85</i> , to <i>5/28</i> , 19 <i>85</i> , that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did not view the body after death.											
22b. SIGNATURE <i>Arnold M. Ward</i>			22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/>	22e. MEDICAL DIRECTOR <input type="checkbox"/>	22f. STAFF PHYSICIAN <input type="checkbox"/>	22g. DATE SIGNED <i>5/28/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. M. Ward</i>			22e. ADDRESS <i>Locust &amp; Quincy Sts., Salisbury, Md. 21801</i>								
23a. BURIAL, CREMATION, REMOVAL SPECIES <i>Burial</i>			23b. DATE <i>5/31/1985</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mardela Memorial Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Mardela</i>	COUNTY <i>Wicomico</i>	STATE <i>Maryland</i>			
24. FUNERAL DIRECTOR <i>Holloway Funeral Home, P.A., Salisbury, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 31 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendleton</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)											

SN221



143124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15560

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mary E. CHILLOUS							5-15-85				8:05 A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		Negro		MONTH	DAY	YEAR	75						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Virginia		U.S.A.						WICOMICO COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		SALISBURY NURSING HOME					Laborer			Seafood			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Dorchester		Cambridge						724 Bayly Rd. 21613			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
		Norman		Chillous				Lucy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		218-10-7306						Veccy Waterman 609 W. 5th St. Wilmington, Delaware					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DOUE TO, OR AS A CONSEQUENCE OF (b) <i>general cerebral sclerosis</i> DOUE TO, OR AS A CONSEQUENCE OF (c) <i>yes</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Diabetic Mellitus</i>													
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED					21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (EXCEPT MEDICAL EXAMINER)		21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21f OR PART 2)								
21h. THE INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>4/28/82</i> to <i>5/15/85</i> hour (I) (we) last and the deceased died on <i>5/14/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. 22b. DEATH CERTIFIED <i>DR. EARL M. BEARDSLEY</i>													
22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			22f. DATE SIGNED <i>5/15/85</i>					
DR. EARL M. BEARDSLEY CIVIC AVE AT RT. 50, SALISBURY, MD. 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE			
Burial		5/18/85		Bethel AME Cemetery			Cambridge			Dorchester Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
		Boardley Funeral Home 812 Hubbard St. Cambridge, Md.			21613 MAY 20 1985			<i>Julia Davidson-Pendell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be signed by the attending physician and completed in by the funeral director. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes" the medical examiner must be informed.

ASIGNI

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or if Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 15561

I. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Rae</b>	MIDDLE <b>G.</b>	LAST <b>CIOTTA</b>	2a. DATE OF DEATH <b>MAY 3, 1985</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>1845 M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 6, 1932</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>			MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Computer Programer C. &amp; P.</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Parkville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1907 Wildwood Avenue 21234</b>				
14. FATHER'S NAME FIRST <b>Leister</b>		MIDDLE <b></b>	LAST <b>Dever Sr.</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Elsie</b>			MIDDLE <b></b>	LAST <b>VanHooiser</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-28-6035</b>			17. INFORMANT <b>Mr. Bart Ciotta Same</b>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>diffuse hypotension spread of Cancer</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (b) (this hospital) attended the deceased from 5/3/85 to 5/3/85, that in (b) (my) opinion death occurred on the date and hour and from the causes stated above (b) (did) (not) view the body after death.												
22b. SIGNATURE <i>Bart Ciotta</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>5/4/85</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.L. Raab Jr.</b>		22f. ADDRESS <b>P.O. Box 2636 Salisbury MD 21801</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 7, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Dulaney Valley Mem.</b>		23d. LOCATION CITY OR TOWN <b>Timonium Balto. Maryland</b>		23e. COUNTY <b>Carroll</b>			STATE	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Gilia Davidson Pendleton</i>							

BRASIL

97 2001 3 month ability extension

Nov 2001

11.6.0 transmission

2001 2001 extension action

periodical 2001 2001 technical

on 2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

2001 2001 2001 2001

141004

5562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.							
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR							2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MAY 8, 1985							1600 M				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			Black		4 - 27 - 1921			64				YRS		MONTHS DAYS HOURS MIN.			
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Maryland			U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital		Domestic			21801									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			617 WESTOVER Circle				21801					
Maryland			Wicomico		Salisbury												
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
Wesley					Coulbourne	Minnie			V.		Viola						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH: Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			265-20-0059		Merrill Cole			Myocardial infarct				7 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)							
DUE TO, OR AS A CONSEQUENCE OF										(c)							
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN				COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-8 1985 to 5-8 1985, that (I) (we) last saw the deceased alive on 5-8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DEGREE		22d. ATTENDING PHYSICIAN			22e. MEDICAL DIRECTOR				22f. STAFF PHYSICIAN					
Julia E. Cope			MD		<input checked="" type="checkbox"/>			<input type="checkbox"/>				<input type="checkbox"/>					
22g. PHYSICIAN'S NAME (TYPE OR PRINT)			22h. ADDRESS									5-8-85					
Burial			23b. DATE 5-13-1985		23c. NAME OF CEMETERY OR CREMATORIAL SPECIFY GREEN ARCS			23d. LOCATION CITY OR TOWN Salisbury				COUNTY STATE Wicomico MD					
24. FUNERAL DIRECTOR NAME Clinton F. Stewart			ADDRESS West Rd Salis. Md		25a. DATE REC'D. BY REGISTRAR MAY 16 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

40028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

144003

5563

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME <small>(TYPE OR PRINT)</small>			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<i>Christine Marie Cooper</i>						<i>MAY 15, 1985</i>				<i>7:30 P.M.</i>
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS. HOURS	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.	
<i>Female</i>	<i>White</i>	<i>MOMM 12 3 1957</i>	<i>27</i>			<i>Wicomico</i>				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(TYPE OR PRINT)</small>					12a USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>				
<i>Salisbury</i>	<i>Peninsula General Hospital</i>					<i>Homemaker Own Home</i>				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE					
<i>MARYLAND</i>	<i>Wicomico</i>	<i>Parsonsburg</i>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	<i>RT#2 Box 5174 21849</i>					
14. FATHER'S NAME <small>(FATHER'S MIDDLE NAME)</small>		15. MOTHER'S MAIDEN NAME <small>(MOTHER'S MIDDLE NAME)</small>								
<i>HARLIA M. BULLIS</i>		<i>Usilla R. OAKES</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO, OR UNKNOWN)</small>		16b SOCIAL SECURITY NO. <small>(IF YES, GIVE WAR OR DATES)</small>		17. INFORMANT		ADDRESS				
<i>No</i>		<i>220-68-8800</i>		<i>Robert Bounds See Sec 13.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hodgkins Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
										<i>1 year</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</small>						
21d. INJURY OCCURRED <small>WHILE AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/></small>		21e PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>5/11</i> , 19 <i>85</i> to <i>5/15</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>5/15</i> , 19 <i>85</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <i>J. E. Martin</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/15/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James E. Martin, M.D.</i>		22e ADDRESS <i>1300 S. Division St., Salisbury, MD.</i>								
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>5-18-1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Springhill Memorial Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Hebron, Wic. Md.</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR <small>(NAME)</small> <i>Baker &amp; Bounds SALISBURY, MD. 21881</i>		25a. ADDRESS <i>201 W. Preston St., Baltimore, MD. 21201</i>		25b. DATE REC'D. BY REGISTRAR <i>20 MAY 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

2000 ft

129608

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15564

REG. NO.

1 - STATE  
REGISTRAR

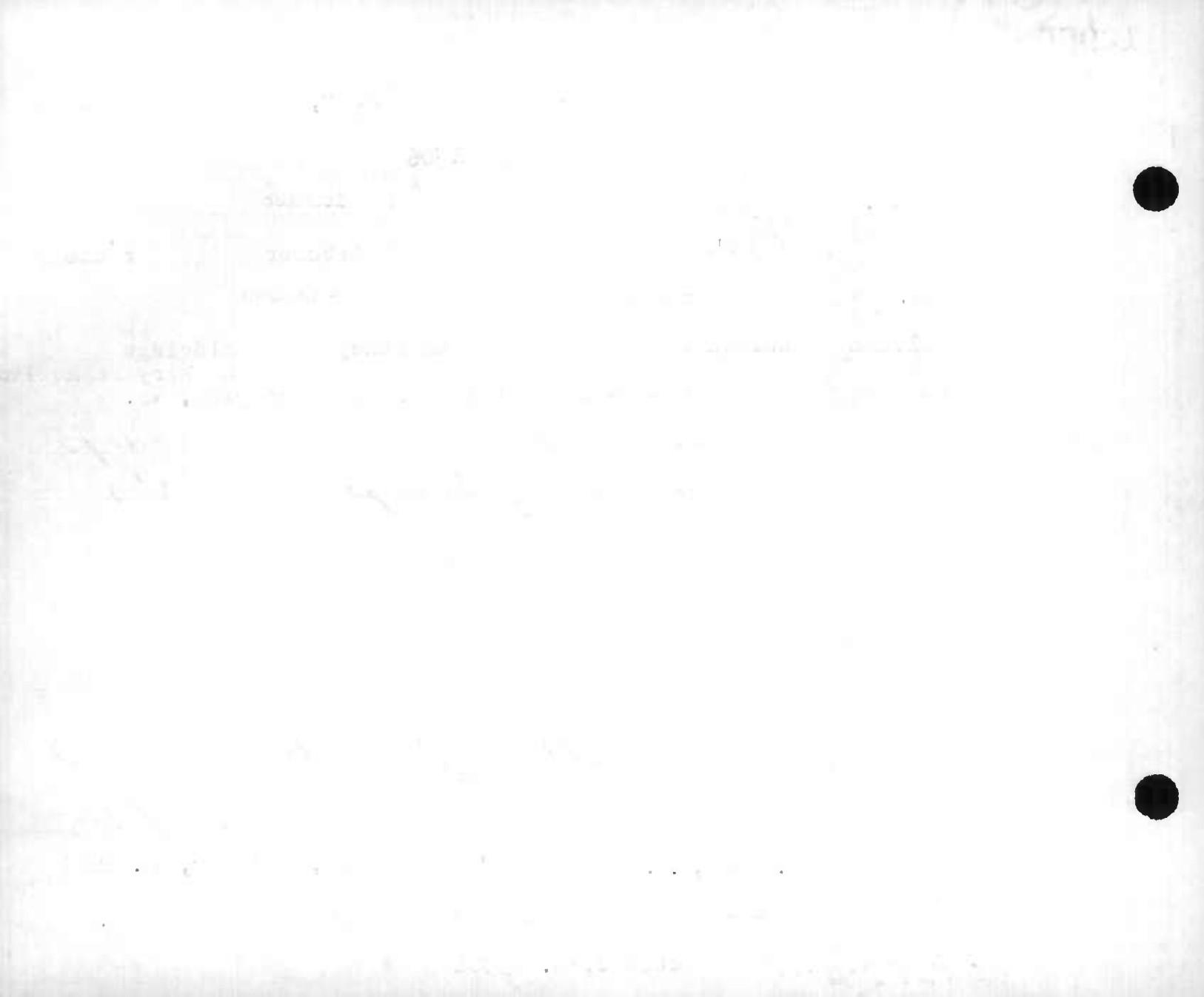
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the Burial/Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
Basil					CUNNINGHAM	May 2, 1985			2:15 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Male		Black		Month June Day 10 Year 1906			78 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Va.		USA					Wicomico									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury		Deer's Head Center			Laborer			Factory								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md.				Baltimore			Unknown			08000						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
William Cunningham					Courtney					Eldridge						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no		217-03-8073			Shirley Brown			42 Mary Peake Blvd								
Hampton, Va.																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Caecum &amp; the larynx</u>												(?)				
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>3/4</u> , 19 <u>85</u> , to <u>5/5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Inja J. Hwang</u>		22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>5/2/85</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Inja J. Hwang, M.D.			22e. ADDRESS			Deer's Head Center, Salisbury, Md. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial		5-8-85		Pleasant Shade			Hampton			Va.						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Edgar Wharton - Accomac, Va.		2330 MAY 8 1985						John Davidson Pendleton								



151016



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filled with 72 hours of death.

IMPORTANT: If item 21 is marked or item 18 show any injury, or other traumatic event, the medical examiner will be called to make a post-mortem examination.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15565

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Annie Mae Dale -</i>				<i>May 18 1985</i>				<i>2330 M</i>
3. SEX <i>female</i>	4. RACE <i>BK</i>	5. DATE OF BIRTH MONTH <i>5</i> DAY <i>12</i> YEAR <i>28</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i>	7. IF UNDER 1 YEAR MONTHS <i>57</i> DAYS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTH PLACE COUNTRY <i>Oney VA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USI</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico MD.</i>				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION <i>DAY CARE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Foster parent</i>		
13a. STATE <i>Md.</i>	13b. COUNTY <i>Worcester</i>	13c. CITY OR TOWN <i>Snow Hill</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>304 Timmon St. 21863</i>				
14. FATHER'S NAME FIRST <i>HARRISON</i> MIDDLE <i></i> LAST <i>KING</i>	15. MOTHER'S MAIDEN NAME <i>MARY</i>			16. ADDRESS <i>Same as above</i>		17. LAST NAME <i>SAMPLE</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>231-42-8755</i>	17. INFORMANT <i>Morris Dale</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i>								
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DO TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Accident Renal Failure</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>544</i>	21f. LOCATION STREET <i>547-D Riverside Dr. Salisbury Md.</i>	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5/18</i> , 19 <i>85</i> , to <i>5/18</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>5/18</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.								
22b. SIGNATURE <i>Benito S. Chan</i>		DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED <i>5/19/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Benito S. Chan</i>		22e. ADDRESS <i>547-D Riverside Dr. Salisbury Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>5/22/85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Wesley U.M. Cemetery Snow Hill Worcester Md.</i>		23d. LOCATION CITY OR TOWN <i>Snow Hill</i>	23e. COUNTY <i>Worcester</i>	23f. STATE <i>Md.</i>		
24. FUNERAL DIRECTOR <i>JOLLEY MEMORIAL CHAPEL</i>	ADDRESS <i>21801</i>	25a. DATE REC'D. BY REGISTRAR <i>MAY 28 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Linda Davidson-Randall</i>				
25c. ATtestation <i>Attest. Jersey Rd. Salisbury, MD.</i>								

3.00121



137032

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified and a report made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15566				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
<u>JOSEPH</u>			<u>LEE</u>			<u>Danmeyer</u>			May 10 1985			1800 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) (LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<u>MALE</u>		<u>WHITE</u>		<u>2-6-20</u>			<u>65</u>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<u>MD</u>		<u>USA</u>					<u>WICOMICO</u>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<u>SALISBURY</u>		<u>PENTAC</u>					<u>CARPENTER</u>			<u>COAST.</u>				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
<u>MD</u>		<u>DOOR</u>		<u>BERLIN</u>					<u>6 MACVIEW- 21811</u>					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
<u>JOSEPH N. DANMEYER</u>		<u>ELsie WELK</u>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<u>YES</u>		<u>4407 21801-2193</u>		<u>EVA B. DANMEYER BERLIN, MD</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>														
DO TO, OR AS A CONSEQUENCE OF (b) <u>cardio pulmonary Arrest</u>														
{ DO TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular Tachycardia</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Ben Meyer</u>		22c. DEGREE <u>M.D.</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>5/10/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ben Meyer</u>		22e. ADDRESS <u>560 Riverside, B101 Salisbury, Md.</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>5/10/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>MD. VETERANS</u>			23d. LOCATION CITY OR TOWN <u>HORNET, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 14 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Sidne Davidson Pendleton</u>		
24. FUNERAL DIRECTOR NAME <u>VELRICH F.N.</u>		ADDRESS <u>BERLIN, MD.</u>												
DHMH - 16 60M 7/84 (VRA 15, 4)														

SEARCHED  
INDEXED  
SERIALIZED  
FILED



158028

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15561

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>ALICE</i>	MIDDLE <i>Dize</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR <i>May 24 1985</i>	MONTH	DAY	YEAR	2b. HOUR <i>8:05 PM</i>	
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 21, 1910</i>			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN <b>Maryland</b> )			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Route 21903</b>		
13a. STATE <b>Maryland</b>			13c. CITY OR TOWN <b>Somerset</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Westovet Star Route 21903</b>		
14. FATHER'S NAME FIRST <b>John</b>			MIDDLE <b></b>	LAST <b>French</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Hester</b>			MIDDLE <b></b>	LAST <b>French</b>	ADDRESS <b>Maryland</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-14-3342</b>			17. INFORMANT <b>Mrs. Vernon Bozman; Upper Fairmount</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINs</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prymyal Cardiovascular Collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> <b>hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Anticoagulant Cardiovascular drug</i> <b>yes</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>COPD</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) <i>fall</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (we) attended the deceased from <i>5/24/85</i> , 19 <i>85</i> , to <i>3/27/85</i> , 19 <i>85</i> , that (we) last saw the deceased alive on <i>5/24/85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/>											
22b. SIGNATURE <i>Arnold M. Lewis MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/24/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. M. Lewis MD</b>			22e. ADDRESS <b>PFHMC</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/27/85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Fairmount</b>			23d. LOCATION CITY OR TOWN <b>Upper Fairmount</b>		
24. FUNERAL DIRECTOR <b>Arnold L. Lewis Funeral Home, Inc.</b>			25a. DATE REC. D. BY REGISTRAR <b>MAY 31 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Barker</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon imprint, pages 1 and 2 should be filed within 72 hours after issuance with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" Item 18 shows any injury or other traumatic event, the medical examiner will be notified of same.

BP \_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

giant

(2)

148142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

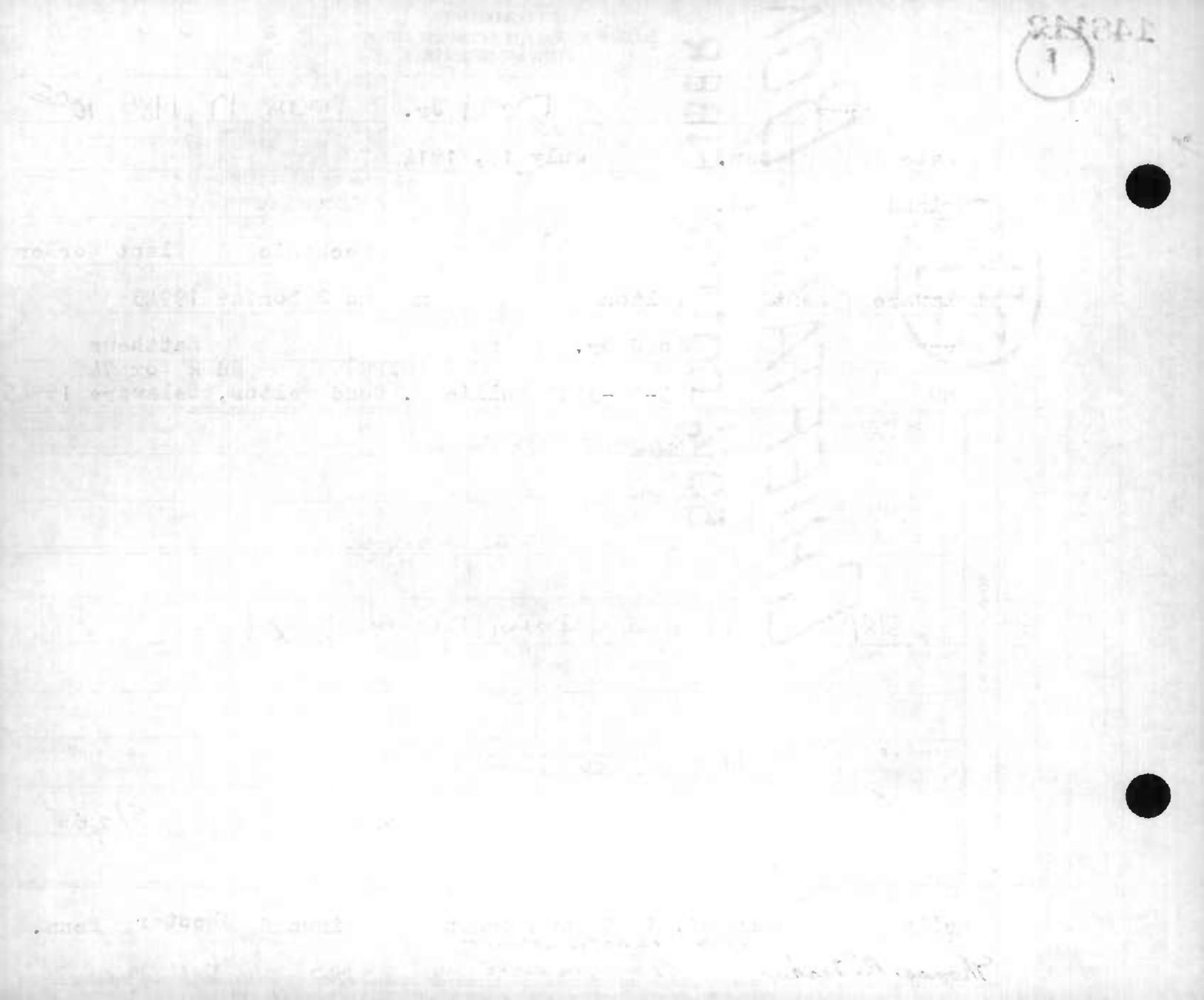
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be affixed to it and the burial permit issued. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked in Item B show any injury, or other traumatic event, the medical examiner must be informed.

15568

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Harry							Dodd Jr.		May 17, 1985					1005 M	
3. SEX <b>Male</b>			4 RACE <b>Cau.</b>		5. DATE OF BIRTH <b>July 19, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS HOURS				
7a. BIRTHPLACE <b>England</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION <b>Mechanic</b>		
13a. STATE <b>Delaware</b>			13c. CITY OR TOWN <b>Kent</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rd 2 Box 749 19943</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plant Worker</b>						
14. FATHER'S NAME FIRST <b>Harry</b>			MIDDLE LAST <b>Dodd Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ann</b>		16. SOCIAL SECURITY NO. <b>163-09-3425</b>		17. INFORMANT (WIFE) ADDRESS <b>Nellie G. Dodd Felton, Delaware 19943</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Persistent V-Tach</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) (c) <b>Coronary Artery Bypass</b>															
19a. DATE OF OPERATION <b>5/8/85</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Artery Disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>51n</b>		21f. LOCATION STREET <b>Linwood</b>		CITY OR TOWN <b>Chester</b>		COUNTY <b>Penn.</b>	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1n</b> , 19 <b>85</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on above, (I) (we) did (and did not) view the body after death.														22c. DATE SIGNED <b>5/17/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Clinch</b>			22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burila</b>			23b. DATE <b>May 21, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lawn Croft</b>		23d. LOCATION CITY OR TOWN <b>Linwood</b>		COUNTY <b>Chester</b>	STATE <b>Penn.</b>					
24. FUNERAL DIRECTOR NAME <b>Thomas R. Treador</b>			ADDRESS <b>12 LOTUS STREET Dover, Delaware</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. E. Kline, D.P.M.</b>								
DHMH - 10-60M 7-84 (VRA 15, 4)															

14245  
1



143094

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15569

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR						
MURPHY O'NEILL DONOHO						MAY 16 1985				1420 M						
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR						
M		W	June 24 1917			67				MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Md.		U.S.A.					Wicomico									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General Hospital			Manager-State of Md.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE				
13d. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge								Rt. 1 Box 7 B	21613			
14. FATHER'S NAME FIRST		MIDDLE			LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE			LAST			
Derry					Donoho	Flossye							Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT				ADDRESS				ITEM #13			
Yes		WW 2			213-01-0200				Elizabeth V. Donoho				Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						CORONARY ARTERY DISEASE - heart						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						CORONARY ARTERY DISEASE						= 20 yrs				
(b)																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Coronary Artery Disease		5-16-85														
19a. DATE OF OPERATION 5-16-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that ( ) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that ( ) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.																
22b. SIGNATURE Nevin W. Rodd, MD		22c. DEGREE MD						22d. ATTENDING PHYSICIAN <input type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 5-16-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEVINS W. RODD, MD		22e. ADDRESS 25 MEDICAL CENTER WEST SALISBURY MD 21801														
23a. BURIAL, CREMATION, REMOVAL (SPECIES) burial		23b. DATE 5/20/85		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Churchyard				23d. LOCATION CITY OR TOWN Church Creek		COUNTY Dor.		STATE Md.				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.						25a. DATE REC'D. BY REGISTRAR MAY 21 1985		25b. REGISTRAR'S SIGNATURE John Davidson Pendleton						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Please 4 in by the funeral director, phone 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Please and 2 when be held within 24 hours after death.

REPORT/AN:

BP \_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/transept permit. Then please remove carbon paper. Pages 1 and 2 would be used within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 26 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

128500 15570

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>WALTER</i>					<i>Dziwanoski</i>	<i>May 2, 1985</i>				<i>10:05 P.M.</i>
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
<i>M</i>	<i>W</i>	<i>4/18/09</i>			<i>76 yrs.</i>					
7c. BIRTHPLACE COUNTRY	7f. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>			MD	
<i>Baltimore</i>	<i>U.S.A.</i>									
10. CITY OR TOWN OF DEATH <i>Salisbury</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>bagelman</i>			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>1336 Ardmore</i>				
14. FATHER'S NAME FIRST <i>Alexander</i>	MIDDLE <i>Dziwanoski</i>	LAST <i>No.</i>	14. MOTHER'S MAIDEN NAME FIRST <i>Dora Gabrovskej</i>			15. ADDRESS <i>116 Oceanview Blvd.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)	16b. SOCIAL SECURITY NO. <i>215-09-3906-A</i>	17. INFORMANT <i>Rita Stevens</i>	18. ADDRESS <i>3906A 9 Clipper Court</i>			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>				
II CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Prostate</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____										
DUE TO, OR AS A CONSEQUENCE OF (d) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Diabetes mellitus</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/28, 1985</i> to <i>5/2, 1985</i> , that (I) (we) last saw the deceased alive on <i>5/2, 1985</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>James E. Martin</i>						DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>5/2/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James E. Martin, M.D.</i>						22e. ADDRESS <i>1300 S. Division St., Salisbury, MD.</i>				
23a. FUNERAL, Cremation, Removal METHOD		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY, STATE, COUNTY				
<i>Burial</i>		<i>5/1/85</i>	<i>Holy Cross Cem.</i>			<i>Bel Air Hwy Md.</i>				
24. FUNERAL DIRECTOR <i>Harold Stevens</i>		25a. DATE REC'D. BY REGISTRAR <i>10/4/85</i>	25b. REGISTRAR'S SIGNATURE <i>Seth Davidson Rendell</i>							
25c. DATE REC'D. BY REGISTRAR <i>MAY 6 1985</i>										

001251

YAM

155141

15571

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	Elliott Elliott	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Miriam Carroll						May	27	1985	1812 M		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White	MONTH	DAY	YEAR	86	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
Reading, Pennsylvania		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		PENINSULA GENERAL MEDICAL CTR. Retired School			1421 Boot Road			Teacher			
13a. STATE Pennsylvania		13b. COUNTY Chester		13c. CITY OR TOWN West Chester	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1421 Boot Road 19380		gtaay		
14. FATHER'S NAME William		MIDDLE	LAST	Rosa	15. MOTHER'S MAIDEN NAME LeVan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO 200-10-1405			17. INFORMANT Phyllis Weiland		ADDRESS 1421 Boot Road West Chester, Pa. 19380			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No											
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>									
		DUE TO, OR AS A CONSEQUENCE OF (b) _____									
		DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>cardiovascular accident; sarcoma; chronic obstructive lung disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. SIGNATURE Rodney A. Wenrich					DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH		22e. ADDRESS 100 POWER ST. SALISBURY Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/30/1985		23c. NAME OF CEMETERY OR CREMATORIAL Grove Methodist Church		23d. LOCATION CITY OR TOWN Grove		COUNTY Chester			STATE Pennsylvania
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 31 1985		25b. REGISTRAR'S SIGNATURE John Davidson Pendell				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

18257



136004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated with a 24 hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										15572					
										REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Lucille Webb			ELZEY			5 3 1985			155 PM			
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female			White			6 15 1921			63						
7. BIRTHPLACE STATE OR FOREIGN			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10b. KIND OF BUSINESS OR INDUSTRY			
Maryland			U.S.A.						Wicomico			Service Rep CT Ptel			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FAMILY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. STREET ADDRESS			MD.			
Salisbury			509 N. DIV ST			Service Rep			509 N. Division St.			2184			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Wicomico			Salisbury						509 N. Division St.			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) 16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Thomas Edward Webb						NINA						NO		218-22-4657 DAVID W. ELSEY 309 N. DIV ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) Carcinoma of Breast with										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to Lungs										3 years		
			DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (his/her) attended the deceased from March 4, 1969, to May 3, 1985, that (I) (we) last saw the deceased alive on May 1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Thomas C. Hill Jr.						DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/3/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. Hill Jr.						22e. ADDRESS Pine Bluff Road, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL RECEIVED			23b. DATE 5/6/1985			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Allen Cemetery Allen			23d. LOCATION CITY OR TOWN WICOMICO MD			23e. COUNTY			
24. FUNERAL DIRECTOR NAME BAKER & BOUNDS			ADDRESS Salisbury, Md. 21801			25a. DATE REC'D. BY REGISTRAR MAY 14 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Bounds						

16000

53543 8111 011500

EN 15121 41 511000 011500  
011500 + h20 (malath)

15121 011500 - 12 VIII 900 1999  
15121 011500 + h20 (malath)

149018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury or other traumatic event, the medical examination should be done with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15573									
1 - STATE REGISTRAR		1. DECEASED NAME <b>Annie ANNIE</b>				MIDDLE <b>Ellen</b>		1 <sup>st</sup> English		2a DATE OF DEATH <b>5/5/85</b>		MONTH <b>May</b>		DAY <b>5</b>		YEAR <b>1985</b>		2b. HOUR <b>3:15 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>MONTH 10 DAY 3 YEAR 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County MD.</b>													
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wicomico Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Garment Co</b>											
13a. STATE <b>MD</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Sharptown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>105 Water Street/21861</b>											
14. FATHER'S NAME FIRST <b>G.</b>		MIDDLE <b>Henry</b>		LAST <b>Jones</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b>		MIDDLE <b>Anne</b>		LAST <b>Kennedy</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Norman W. Ellis</b>		ADDRESS <b>104 Water Street Sharptown, MD 21861</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>CVA</b> IMMEDIATE CAUSE (a) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 w</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <b>ASCVD, = atrial Fib.</b>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arthritis.</b>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 19		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) <b>at home</b>		21e. LOCATION STREET <b>Oct 87</b>		CITY OR TOWN <b>5-655-85</b>		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-1-85</b> 19 <b>85</b> to <b>5-6-85</b> 19 <b>85</b> , that (II) (we) last saw the deceased alive on <b>5-1-85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/>																			
22b. SIGNATURE <b>L.V. MALDIVE, M.D.</b>		22c. DEGREE <b></b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <b>5-6-85</b>													
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L.V. MALDIVE, M.D.</b>		22g. ADDRESS <b>1814 Kipling Rd, Salisbury, Md, 21801</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-8-85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Sharptown Firemens Cem.</b>		23d. LOCATION CITY OR TOWN <b>Sharptown</b>		23e. COUNTY <b>Wicomico</b>		23f. STATE <b>MD</b>					
24. FUNERAL DIRECTOR <b>Zeller Funeral Home, Sharptown, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1985</b>		25b. REGISTRAR'S SIGNATURE <b>maureen pardee</b>															

referred

(A)

on August 20, 1952.

1. The cause was a ruptured aorta.

2. The patient had been well until 1951.

3. He had a history of hypertension.

400

4. His pulse was 10528.

5. His blood pressure was 160/100.

6. His heart rate was 100.

7. His respiration was 24.

8. His temperature was 98.6.

9. His blood pressure was 160/100.

137033

15574

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

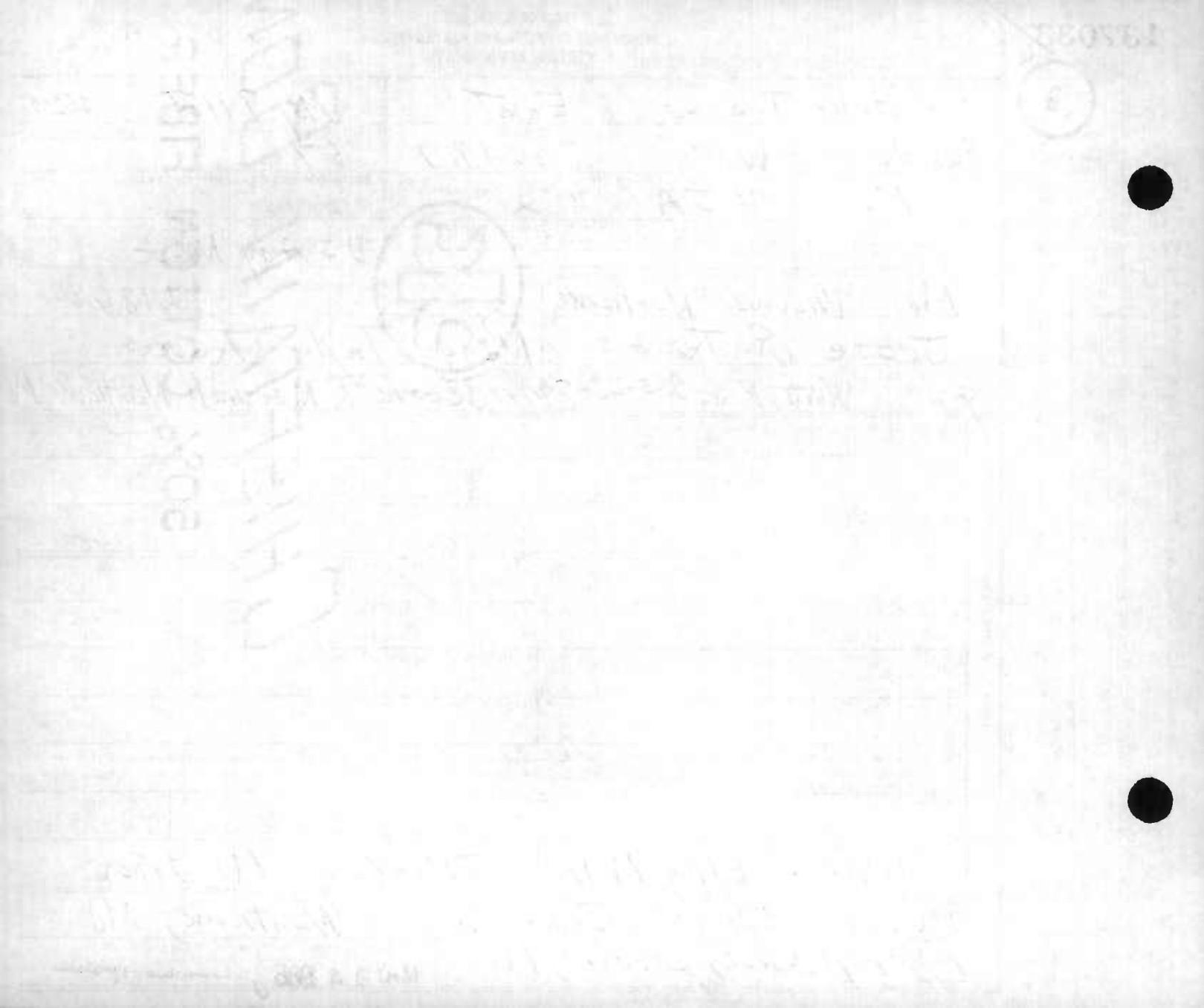
REG. NO.

1. FOR STATE REGISTRAR			Estelle Travers Ernst								
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Estelle Travers				Ernst	May 9, 1985		1985	9	1985	0530a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS AS OF BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		8-24-1917		67		MONTH		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.	
MI		V.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Wicomico		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (IF WORK FOR PAY OR OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				U.S. Army Nurse					
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		Wicomico		Nanticoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21840			
14. FATHER'S NAME											
Jesse R. Travers											
15. MOTHER'S MAIDEN NAME											
Nancy Taylor Travers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (ENTER NO OR UNKNOWN)											
16b. SOCIAL SECURITY NO											
Yes WWII Korea 215-38-8941 Jessie T. Marshall Nanticoke, MD											
17. INFORMANT											
ADDRESS											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory esophageal varices 3 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) cultures of lung conclusion											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		P.M.		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME STREET, FACTORY, OFFICE, FARM, ETC.		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-5 1985 to 5-9 1985, that (I) (we) last saw the deceased alive on 5-9 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE											
Walter A. Ellis M.D.											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Walter A. Ellis M.D.		581156ux, Md 21840				5-9-85					
23a. BURIAL, CREMATION, REMOVAL (IF APPLICABLE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL TURKEY CORN.		23d. LOCATION CITY, TOWN		COUNTY		STATE	
Burial		5/13/85		Turkey Corn.		Nanticoke, MD					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
E. Messick, Bivalve, MD		MAY 14 1985		murrison-pendleton							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 &amp; 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



144116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15575				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
EVELYN CATHERINE FISHER							5 19 85						11:15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Female		White		12 14 1927		57				MONTHS	YRS.	MONTHS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				Wicomico MD.		
Maryland		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Pitts St. P.O. Box 174				Garment Factory								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				
Maryland		Wicomico		Pittsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Pitts St. P.O. Box 174 21850				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST				MIDDLE				
John		S.		ESHAM		EVA				Hudson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		213-22-9254		MILTON J. Fishen Sn				See Sec 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Joseph A. Grasso, M.D.</i> DEGREE <i>MD</i>														
22c. PHYSICIAN'S NAME, TITLE OR PRINT <i>Joseph A. Grasso, M.D.</i>		22d. ADDRESS <i>1400 S. Division St. Salisbury MD 21801</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>5/20/85</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5-21-1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Pittsville cem</i>		23d. LOCATION CITY OR TOWN <i>Pittsville Wic MD</i>								
24. FUNERAL DIRECTOR <i>Baker &amp; Bounds SALISBURY, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1985</i>				25b. REGISTRAR'S SIGNATURE <i>John R. Johnson</i>								

三

六  
卷之二

137100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use of the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

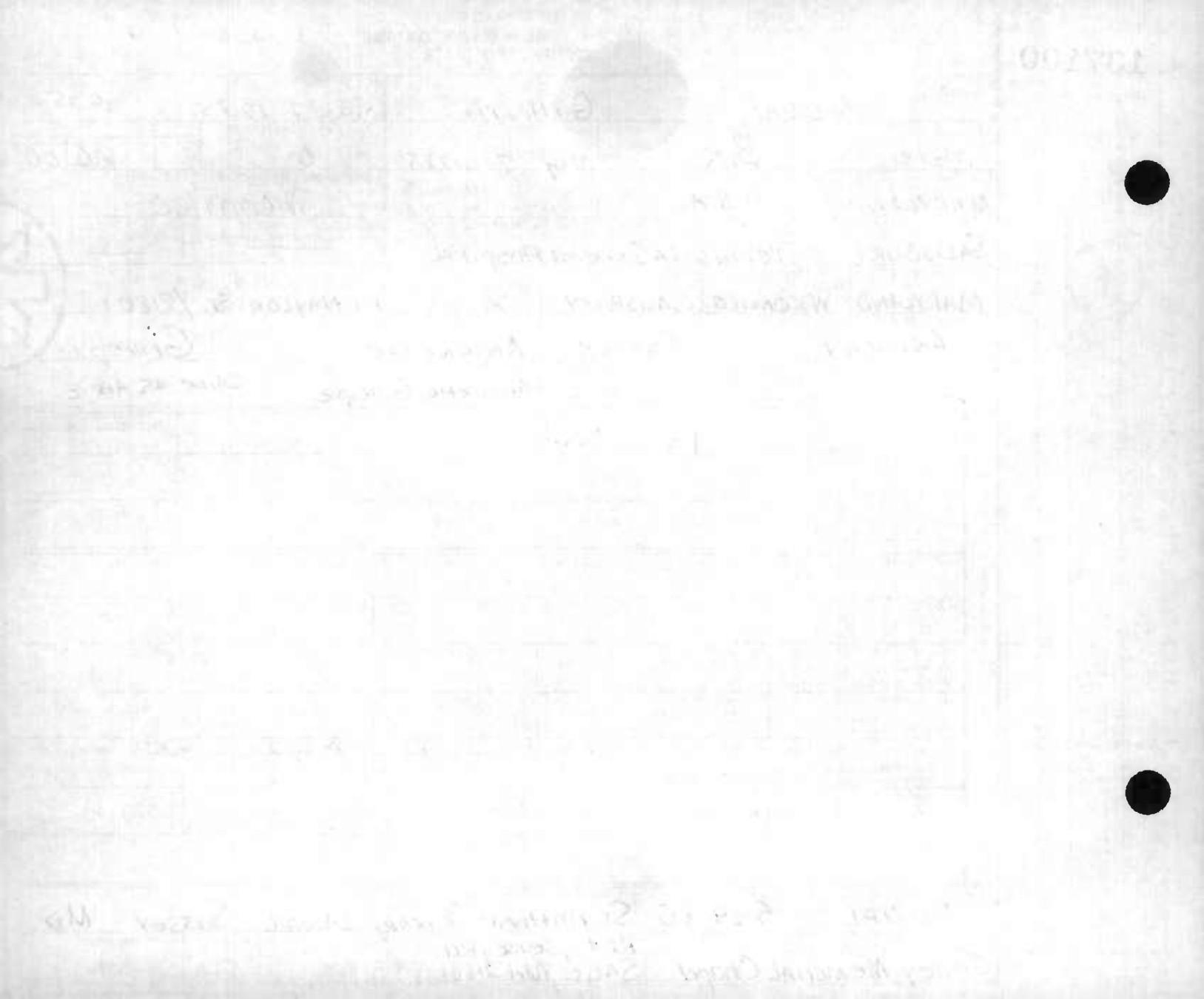
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 15516

1. STATE REGISTRAR												
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Leon			Gillespie			May 7 1985			0358 AM			
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			
Male			Black			May 7 1985			0 994 yrs			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			IF UNDER 1 YEAR MONTHS DAYS			
MARYLAND			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			IF UNDER 24 HRS MONTHS DAYS			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY			Peninsula General Hospital									
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			WICOMICO			SALISBURY			111 NAYLOR ST. 21801			
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			
ANTHONY			ANJANETTE PARKER						16c INFORMANT Anjanette Gillespie			
									ADDRESS Same AS ABOVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from May 7 1985 to May 7 1985, that (I) (we) last saw the deceased alive on May 7 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Brij Lal Agarwal</u>			DEGREE <u>MS</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/7/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-09-85			23c. NAME OF CEMETERY OR CREMATORIAL St. Matthews Cemetery			23d. LOCATION CITY OR TOWN LAUREL COUNTY SUSSEX STATE MD.			
24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u>			ADDRESS Rt. #2, Jersey Rd. Salisbury, Md. 21801			25a. DATE REC'D. BY REGISTRAR MAY 15 1985			25b. REGISTRAR'S SIGNATURE <u>John K. Knudsen, Jr.</u>			

002701



144091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the final funeral permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Director of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is initialed or signed, it shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15511					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 5/17/85							2b. HOUR 10 P.M.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILSON	MIDDLE TRUITT	LAST GILLIS			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 03 04 1913			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR			12b. KIND OF BUSINESS OR INDUSTRY BUILDER			
10. CITY OR TOWN OF DEATH Salisbury			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. CITY OR TOWN WICOMICO			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1508 SPRINGHILL ROAD 21801			
14. FATHER'S NAME FIRST WILLIAM			MIDDLE TRUITT	LAST GILLIS			15. MOTHER'S MAIDEN NAME FIRST AGNES			MIDDLE VIRGINIA	LAST JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-10-7691A			17. INFORMANT MRS. AMY H. GILLIS (WIFE) SAME AS #13E									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Shock</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hour</i>					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last <i>accident Marjorale after</i> DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>at time of death</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/17/85</i> , to <i>5/17/85</i> , that (I) (we) lost saw the deceased alive on <i>5/17/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death															
22b. SIGNATURE <i>John Gary Green</i>										DEGREE	22c. DATE SIGNED <i>5/17/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Gary Green</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> ADDRESS 21801 LOCUST & QUINCY STS., SALISBURY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 5/20/1985			23c. NAME OF CEMETERY OR CREMATORIAL MARDELA CEMETERY			23d. LOCATION CITY OR TOWN MARDELA		COUNTY	STATE			
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, SALISBURY, MD.									25a. DATE REC'D. BY REGISTRAR MAY 21 1985		25b. REGISTRAR'S SIGNATURE <i>La Davidson Pendle</i>				

18941



135635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15578

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Minnie</i>	MIDDLE <i>M.</i>	LAST <i>Gordy</i>	2a. DATE OF DEATH MONTH <i>10</i>	DAY <i>3</i>	YEAR <i>1909</i>	2b. HOUR 26 HOUR <i>642 M</i>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <i>10</i>			DAY <i>3</i>	YEAR <i>1909</i>	6. AGE IN YEARS LAST BIRTHDAY <b>75</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>	IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hebron, Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>			MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Linen Dept.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>225 Lakewood Drive 21801</b>				
14. FATHER'S NAME FIRST <b>Lloyd</b>		MIDDLE <b>George</b>		LAST <b>Hopkins</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Fannie</b>		MIDDLE <b>Darby</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-10-3894</b>		17. INFORMANT ADDRESS <b>Mr. John L. Gordy (Husband)</b> Same as #13e								
18. CAUSE OF DEATH (Enter only one cause per line item 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RERACTRY Congestive heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Artherosclerotic Cardiovascular Disease										
		DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/9</b> , 19 <b>85</b> , to <b>5/9</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did not) view the body after death.												
22b. SIGNATURE <i>Donald M. Woods</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>5/9/85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. M. Woods, MD</b>		22e. ADDRESS <b>PBMHC</b>				, Salisbury, Maryland 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/12/1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hebron Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hebron</b>		COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home, P.A.</b>		ADDRESS <b>Salisbury, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Ronald R. Woods</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

W.W. Watylaud

Micro W

158153

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) <b>REUBEN Lester HALES</b>				2a. DATE OF DEATH MONTH <b>5</b>	MONTH DAY <b>22</b>	YEAR <b>85</b>	2b. HOUR 5:25 p.m.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>2/11/97</b>	YEAR <b>97</b>	6. AGE [IN YEARS LAST BIRTHDAY] <b>88</b>	IF UNDER 1 YEAR MONTHS <b>88</b>	IF UNDER 24 HRS DAYS <b>88</b>	2b. HOUR HOURS <b>5:25</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b>				
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SALISBURY NURSING HOME</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Truck Farm</b>				
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Rt 4- Box 168 / 21801</b>
14. FATHER'S NAME FIRST <b>William</b>	MIDDLE <b>Thomas</b>	LAST <b>Hales</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Lucinda</b>	MIDDLE <b></b>	LAST <b>Townsend</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 1 220 12 1056</b>	17. INFORMANT <b>Shirley H. Townsend, Rt. 4, Salisbury, Md.</b>	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Reuben Vassader accident</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 day.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <i>generalized allergic reaction</i>  (c) <i>yes</i>						DUE TO, OR AS A CONSEQUENCE OF  DUE TO, OR AS A CONSEQUENCE OF  (c) <i>yes</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1985</b> to <b>1985</b> , that (I) (we) last saw the deceased alive on <b>1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Reuben</i>		DEGREE <b>40</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/23/85</b>			
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/25/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Olive</b>	23d. LOCATION CITY OR TOWN <b>Snow Hill, Maryland</b>	23e. COUNTY <b>Snow Hill, Maryland</b>	23f. STATE <b>Snow Hill, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Norman F. Dennis</b>	ADDRESS <b>Snow Hill, Maryland</b>	25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1985</b>	25b. REGISTRAR'S SIGNATURE <i>Julie Larson</i>				

100023



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my best.

referred by the hospital or attending physician.

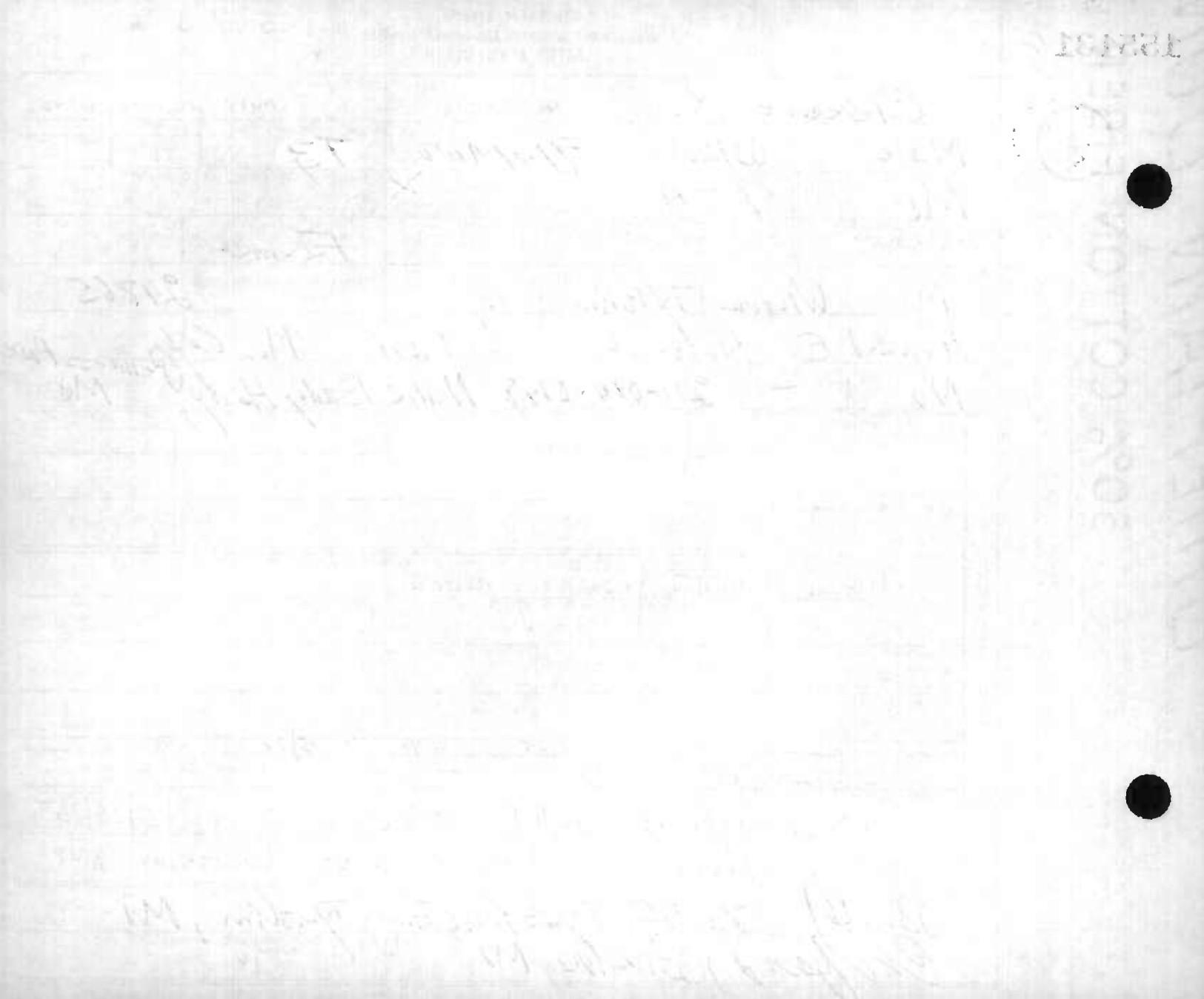
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 2 &amp; 3 would be used when 2 pages are needed with the State Dept. of Health and Mental Hygiene prior to burial, examination, or removal.

IMPORTANT: If Item 18 is marked or Item 19 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15580					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Chance R.						HOLBROOK MAY 26, 1985			0745 M						
3. SEX Male			4 RACE Black			5. DATE OF BIRTH 8-16-1910			6. AGE (IN YEARS LAST BIRTHDAY) 74			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN Country: MI			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
11. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY			MD.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Wicomico			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21865						
14. FATHER'S NAME FIRST MIDDLE LAST Howard E. Holbrook			15. MOTHER'S MAIDEN NAME Lillian			16. SOCIAL SECURITY NO. 216-09-4074			17. INFORMANT ADDRESS Nellie Bailey Hardy			LAST MS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No			16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			(b)			DUE TO, OR AS A CONSEQUENCE OF									
			(c)			DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
chronic obstructive pulmonary disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5/25 1985 to 5/26 1985 that (I) (we) last saw the deceased alive on 5/26 1985 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.															
22b. SIGNATURE Rodney A. Wenrich, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/26/85						
22d. PHYSICIAN'S NAME TYPE OR PRINT RODNEY A. WENRICH			22e. ADDRESS 100 POWER ST. SALISBURY MD.												
23a. BURIAL, CREMATION, REMOVAL SPECIFY: Burial			23b. DATE 5/3/85			23c. NAME OF CEMETERY OR CREMATORIAL Tyls King Com.			23d. LOCATION Middlin, MD			STATE Maryland			
24. FUNERAL DIRECTOR															
25. DEATH REGISTRY NUMBER: MAT 31 1985						25b. REGISTRAR'S SIGNATURE									

21788



149020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5581

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bernice Bennice</i>				FIRST <i>Bernice</i>	MIDDLE <i>Virginia</i>	LAST <i>Hopkins</i>	2a DATE OF DEATH <i>MAY 20, 1985</i>	MONTH <i>JUN</i>	DAY <i>20</i>	YEAR <i>1985</i>	2b. HOUR <i>0730 M</i>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>26</b> YEAR <b>1897</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a BIRTHPLACE COUNTRY <b>Quantico, Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>						
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Seamstress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>						
13a STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route #5 Crooked Oak Lane 21801</b>					
14. FATHER'S NAME FIRST <b>Cadmus</b>		MIDDLE <b>Bailey</b>		LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>		MIDDLE <b>Virginia</b>		LAST <b>Reddish</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-10-2475</b>		17. INFORMANT <b>Mr. Andrew J. Hopkins (Son)</b> Same as #13e		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)				<i>Ventricular fibrillation</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Acute myocardial infarction</i>						DAYS <i>Day</i>					
		(c) <i>Allergies</i>						YEARS <i>Year</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Other coronary disease</i>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>5110 Locust St., Salisbury, Md.</i>		21f. LOCATION STREET <i>Locust &amp; Quincy Sts., Salisbury, Md.</i>		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>5/10/85</i> to <i>5/20/85</i> , that (I/we) last saw the deceased alive on <i>5/20/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John G. Green, M.D.</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/20/85</i>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John G. Green, M.D.</b>				22e. ADDRESS <b>Locust &amp; Quincy Sts., Salisbury, Md. 21801</b>									
23a. BURIAL, CREMATION, REMOVAL ISPART OF <b>Burial</b>		23b. DATE <b>5/23/1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Wicomico Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Salisbury</b>		COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home, P.A., Salisbury, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 24 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Yandek</i>									
BP _____													
DHMH - 16 60M 7/84 (VRA 15, 4)													

000001

155129  
 NO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. RETAIN PAGE 5 FOR YOUR FILES.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1-  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15582

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>EVA</b>	MIDDLE	LAST <b>HUDSON</b>	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH 5	DAY 21	YEAR 85	2b. HOUR 2055M	
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>07 28 1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87RS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>5-21-85</b>	MONTH 5	DAY 21	YEAR 85	2d. HOUR 2055M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>				
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>DELAWARE</b>	13b. COUNTY <b>SUSSEX</b>	13c. CITY OR TOWN <b>DAGSBORO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>RD #1 BOX 178 99999</b>					
14. FATHER'S NAME FIRST <b>JESSE CLAYTON ROWE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARY TAYLOR ROWE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>221-28-2201</b>		17. INFORMANT <b>MRS. JOHN MC CABE</b>		ADDRESS <b>RD #1 BOX L78 DAGSBORO, DE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/>										and in my opinion
ACTUAL SIGNATURE <i>John T. Bulkeley</i>		TITLE (SPECIFY) <b>Deputy</b>		M.D.		MEDICAL EXAMINER				DATE SIGNED <b>5-23-85</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>John T. Bulkeley, M.D.</b>		ADDRESS <b>Pine Bluff Rd., Salisbury, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAY 24 85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>CAREY'S CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>FRANKFORD SUSSEX DE</b>				
24. FUNERAL DIRECTOR NAME <b>MELSON FUNERAL SVCS.</b>		ADDRESS <b>THATCHER STREET FRANKFORD, DE</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Karen Pendleton</i>				
BP		DHMH 17		VR A15 ME (5)		20M 4/82				

卷之三

6

四

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15583

141150

1 - FOR  
STATE  
REGISTRAR

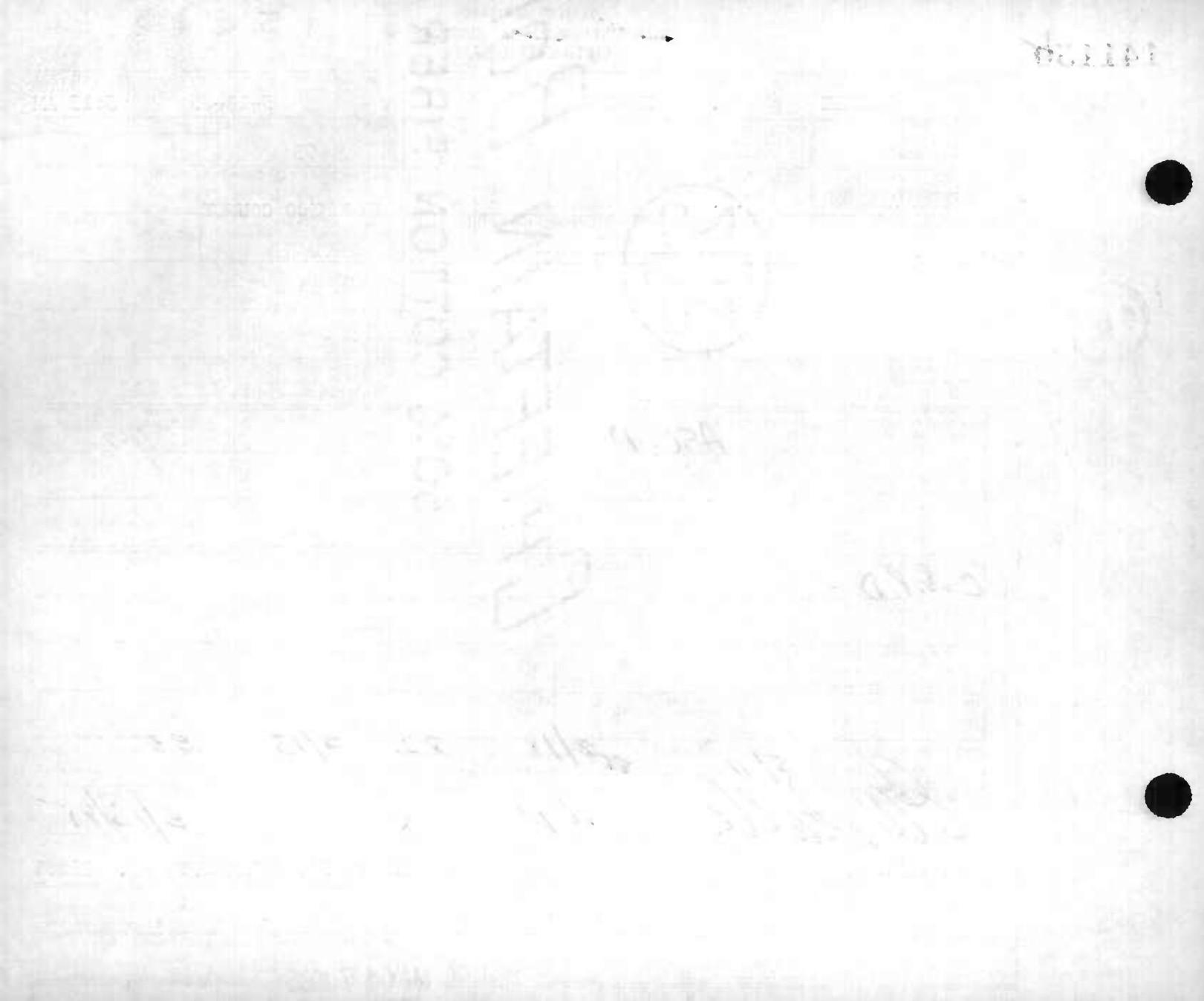
REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
LILLIE D. HUDSON				5-13-85	5:15 AM
3. SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR OCTOBER 4 1889	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY DELAWARE		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME			
13a STATE DELAWARE		13b COUNTY SUSSEX	13c CITY OR TOWN FRANKFORD	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE SUSSEX 54 19945
14 FATHER'S NAME FIRST MIDDLE LAST WINGATE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTHEWS LIZZIE MATTHEWS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 221-50-5119		17 INFORMANT ADDRESS CALVIN HUDSON FRANKFORD, DELAWARE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVD</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i> yrs</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>C.O.P.D.</i>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
22d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22g I certify that (I) (the hospital) attended the deceased from <i>3/18</i> to <i>5/15</i> , 19 <i>85</i> , to <i>5/15</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/18</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22h SIGNATURE <i>DR. EARL M. BEARDSLEY</i>					
DEGREE <i>MD</i>					
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22i PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY					
22e ADDRESS CIVIC AVE, AT RT. 50, SALISBURY, MD. 21801					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/15/85	23c NAME OF CEMETERY OR CREMATORIAL CAREY'S CEMETERY		23d. LOCATION CITY OR TOWN FRANKFORD COUNTY SUSSEX STATE DELAWARE
24 FUNERAL DIRECTOR NAME MET-SONS FUNERAL SERVICE ADDRESS THATCHER FRANKFORD DE					
25a DATE REC'D. BY REGISTRAR MAY 17 1985					
25b REGISTRAR'S SIGNATURE <i>John Baird, Jr. Beardsley</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

 999999  
BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)



141045 15584

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Louis						IRVIN		APRIL 26			1985	1015 M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		Black		MONTH DAY YEAR		4 - 10 - 1896		89	MONTHS	YEARS	HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Louisiana		U.S.A									Wicomico MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						LABORER				21801 S. Wacoming Dr. Salisbury, Md.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		32 Wacoming Dr. 21801 S. Wacoming Dr. Md.					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
WAT						LEAH CARR							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		WAT				Leah Carr 32 Wacoming Dr. Salisbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days	
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Atherosclerotic Parkinson's.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-13 1985 to 4-26 1985, that (I) (we) last saw the deceased alive on 4-26 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not sign the body after death.												22c. DATE SIGNED 4-26-85	
22b. SIGNATURE <i>John E. Crosthwaite</i>		22d. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Crosthwaite		22f. ADDRESS 531 Riverside, Salisbury MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-5-85		23c. NAME OF CEMETERY OR CREMATORIAL Belleville Cemetery		23d. LOCATION CITY OR TOWN Suffolk		CITY OR TOWN Newesmond		COUNTY Va			
24. FUNERAL DIRECTOR NAME Clinton F. Stewart		ADDRESS West Rd. Salisbury, MD.						25a. DATE REC'D. BY REGISTRAR MAY 16 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the burial permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

卷之三

二〇一九

لـ ۷

Digitized by

卷之三

~~not consider the result yet~~

*W. H. D. - 1906*

*an old man*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

149075

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15585

REG. NO.

1 - STATE REGISTRAR			20. DATE OF DEATH MONTH DAY YEAR						2b HOUR A 3:40 M						
1. DECEASED NAME FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
Anna H. JONES			March 3, 1914			71 YRS.									
3. SEX		4. RACE		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
Female		White		USA											
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Pennsylvania		Salisbury		Deer's Head Center			Bookkeeper			Paper Co.					
13a. STATE Maryland						13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 501 Pacific Avenue 21801			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Harry Hilsee Sally M. Baker															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		173-05-5491		Linda J. Kitchens, Bishopville, MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant colicexia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of uterus with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/17 19 85 to 5/23 19 85, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>M. Shrestha</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 5.23.85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAHESWARI SHRESTHA M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-25-85		23c. NAME OF CEMETERY OR CREMATORIAL Bishopville		23d. LOCATION Bishopville Worcester MD		25a. DATE REC'D. BY REGISTRAR MAY 27 1985		25b. REGISTRAR'S SIGNATURE <i>Charles W. Hartman, Salisbury, Del.</i>					
24. CEMETERY DIRECTOR NAME ADDRESS <i>Charles W. Hartman, Salisbury, Del.</i>															

35691

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death, and should be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, please remove carbon paper. Print on the back of this certificate and mail it in 24 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 is marked, attach a separate sheet of paper for the medical certification.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15586

REG. NO.

1 - FOR STATE REGISTRAR			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	May 29, 1985 1845 M		
Daisy B. Jones				B.	Jones			
3 SEX		4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
Female		Black	7 - 23 - 1915			69 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland		U.S.A.			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			
Salisbury		Peninsula General Hospital			12b. KIND OF BUSINESS OR INDUSTRY 21601			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE	13b COUNTY	13c CITY, OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 609 Delware Ave Salis. Md.		
Maryland	Wicomico	Salisbury						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			
Asbury				Nelson	16. INFORMANT			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17. ADDRESS			
No		27-10-3769			William Jones 1321 Passage Dr Odenton. MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral cerebral hemorrhage 18 hours								
DO TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis								
DO TO, OR AS A CONSEQUENCE OF (c) Hypertension								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Coronary artery disease . Mental regression taken								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19a		19b			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)			21f LOCATION STREET	CITY OR TOWN	COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 5/27, 19_____, to 5/27, 19_____, that (I) (we) last saw the deceased alive on 5/28, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>B. A. Jarval</i>		22c. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED JUN 5 1985			
THE PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. A. Jarval</i>		22e ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 6-4-85	23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Memory Gardens			23d. LOCATION CITY OR TOWN Hebron	COUNTY Wicomico	STATE Md.
24 FUNERAL DIRECTOR NAME Clinton F. Stewart		ADDRESS West Rd Salisbury, MD.	25a. DATE REC'D. BY REGISTRAR JUN 5 1985			25b. REGISTRAR'S SIGNATURE <i>Julia L. Anderson-Pandell</i>		

191-83-6

24.2 is being considered

236

- 2 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

158138

Film G606 item.5,6,

FOR 8/8/85 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15587

1. STATE REGISTRAR

REG. NO.

(TYPE OR PRINT)

WALTER -

Justice

3. SEX

MALE

4. RACE

WHITE

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

10 CITY OR TOWN OF DEATH

Salisbury

13a STATE

Maryland

13b COUNTY

Wicomico

13c CITY OR TOWN

Delmar

13d INSIDE CITY LIMITS?

YES  NO 

13e STREET ADDRESS / ZIP CODE

LOT A-3 Wicomico PK 21875

14. FATHER'S NAME

DONALD

FIRST MIDDLE

Justice Sr

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

yes Korea War. 213-22-8147

16b SOCIAL SECURITY NO.

17. INFORMANT

NANCY Driscoll, Lot G1 Naylor Rd, MD 21801

ADDRESS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES  NO 

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES  NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE  NOT WHILE AT WORK  AT WORK 

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

above, (I) (we) (did) (did not) view the body after death.

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

19

2015

1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 5 8 8

160013

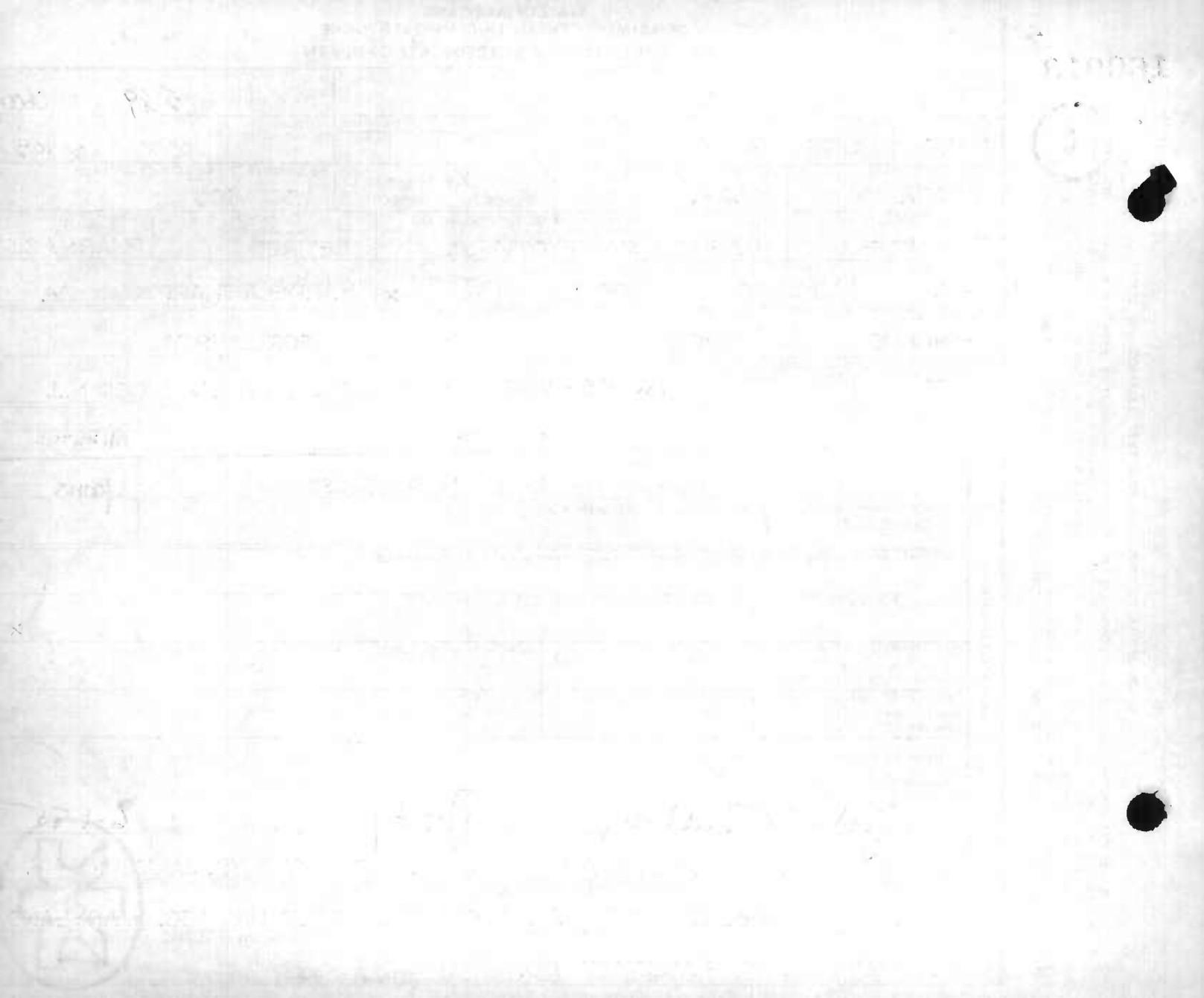
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR		
MAURICE R. KOoba						<input checked="" type="checkbox"/>	5/28	T9	85	0600		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 83 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
MALE	WHITE	10/02/02				05/31	T9	85	1045	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA		U.S.A.					WICOMICO					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
MARDELA		MARDELA SHARPTOWN RD.			RETIRED		PHARMACIST					
13a. STATE Md.		13b. COUNTY WICOMICO	13c. CITY OR TOWN MARDELA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MARDELA SHARPTOWN Rd.		21837				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
PINCHUS			KOoba	IDA		SOSZLAVSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
YES		131-05-4705			BARBARA SHULMAN		LAKEWOOD N.J.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											Minutes	
(b) GENERALIZED ARTERIAL SCLEROSIS											Years	
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Dr. JOHN T. BULKELEY			TITLE (SPECIFY) M.D. Deputy						MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		Dr. JOHN T. BULKELEY			ADDRESS S.SALISBURY BLVD. SALISBURY Md.						DATE SIGNED 6-1-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
BURIAL		06/02/85		BETH ISRAEL CEMETERY SALISBURY WIC. MARYLAND								
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HOLLOWAY FUN. HOME SALISBURY MD.					JUN 6 1985		John G. Bulkeley					
BP												
DHMH - 17 (VR A15 M) 20M 4/82												



**NO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death sentence be carried out within 24 hours after death Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN: The

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be held within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15589

REG. NO.

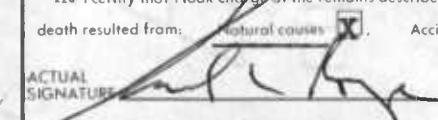
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR	2b HOUR
BESSIE H. Larrimore						May 27 1985	1911 M
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (IN YEARS AT BIRTHDAY)	
Female	White	MONTH DAY YEAR	Aug 17, 1911			73	IF UNDER 1 YEAR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Laurel, Delaware USA					Wicomico MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital				Homemaker		own home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
Delaware	Sussex	Laurel	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RD 3 Box 65			99999
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
Eli Hastings				Annie Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				
no	221 07 7075	Mr. Isaac L. Larrimore	Laurel, Del 19956 RD 3 box 65				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic heart disease</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
For <i>Aortic stenosis &amp; mitral insufficiency</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)						
22a. I certify that <input checked="" type="checkbox"/> (the deceased) attended the deceased from <i>5/27/85</i> 19 to <i>5/27/85</i> 19, that <input checked="" type="checkbox"/> (he/she) saw the deceased alive on <i>5/27/85</i> 19, and that in my <input checked="" type="checkbox"/> (his/her) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Charles Raab</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>5/27/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles Raab M.D.</i>	22e. ADDRESS <i>P.O. Box 2636 Salisbury MD 21801</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE May 31, 1985	23c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery	23d. LOCATION CITY OR TOWN Laurel	23e. COUNTY STATE Sussex Delaware			
24. FUNERAL DIRECTOR NAME Homer L. Disharoon	ADDRESS Box 678 Laurel Del 19956	73a. DATE REC'D. BY REGISTRAR JUN 04 1985	73b. REGISTRAR'S SIGNATURE <i>Jeha L. Disharoon</i>				



144110

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT; PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 15590								
1. DECEASED NAME (TYPE OR PRINT)			FIRST RAYMOND			MIDDLE B.			LAST LORD			2a. DATE KNOWN OF DEATH ESTIMATED	MONTH 5	DAY 15	YEAR 85	2b. HOUR 0346 M				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH June DAY 26 YEAR 1919			6. AGE (IN YEARS LAST BIRTHDAY) 65 yrs			7f. IF UNDER 1 YR. MONTH	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD 5-15-85	MONTH 5	DAY 15	YEAR 85	2d. HOUR 0346 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cheswold, Del.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico								
CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. from Preston			12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.											
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Rhodesdale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Box 66			21659					
14. FATHER'S NAME FIRST Leonard F. Lord			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Frances Mae Jester											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. IF YES, GIVE WAR OR DATES WWII			16c. SOCIAL SECURITY NO.			17. INFORMANT Ida Mae Lord, Rt. 1, Box 66, Rhodesdale, Maryland			ADDRESS Maryland 21659								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												and in my opinion								
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER												DATE SIGNED 5-16-85								
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 18, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Eldorado Cemetery			23d. LOCATION CITY OR TOWN Eldorado			COUNTY Dorchester			STATE Maryland					
24. FUNERAL DIRECTOR NAME Frampton-Hawkins, Federalsburg, Md.			25a. DATE REC'D. BY REGISTRAR MAY 22 1985						25b. REGISTRAR'S SIGNATURE 											
BP																				
DHMH - 17 (VR A15 ME (5)) 20M 4/82																				

卷之三

144084

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS) AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE   559   MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-18 19 85									2b. HOUR 2d. HOUR M 4:44 a.m.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Michael J.			MIDDLE Mammano			LAST							
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16 1965 20			6. AGE (IN YEARS LAST BIRTHDAY) YRS. YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD.								
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) College Student			12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Berkshire			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6517 Lacona Street					
14. FATHER'S NAME FIRST Frank			MIDDLE J.			LAST Mammano			15. MOTHER'S MAIDEN NAME FIRST Judith			MIDDLE A.			LAST Rohan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS 6517 Lacona St.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			578-82-8584			Frank & Judith Mammano Berkshire, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8820</b> IMMEDIATE CAUSE (a) <b>Craniocerebral Trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:10 AM 5-18 1985</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject fell from roof of building</b>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion <input checked="" type="checkbox"/> Co. Md.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>college</b>			21f. LOCATION STREET <b>Salisbury State College, Salisbury, Wicomico</b>										
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>						TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER			DATE SIGNED <b>5-19-85</b>				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS <b>111 Penn St., Balto., Md. 21201</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <b>5/21/85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Suitland</b>			COUNTY STATE <b>P.G. Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>			ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Dawson</i>							
DV			BP			DHMH - 17 (VR A15 ME (5))										



values

second or else?

counts around 100

motion

atoms

atmospheric oxygen atoms

approximately 1000

atoms in the air

YAH

134604

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

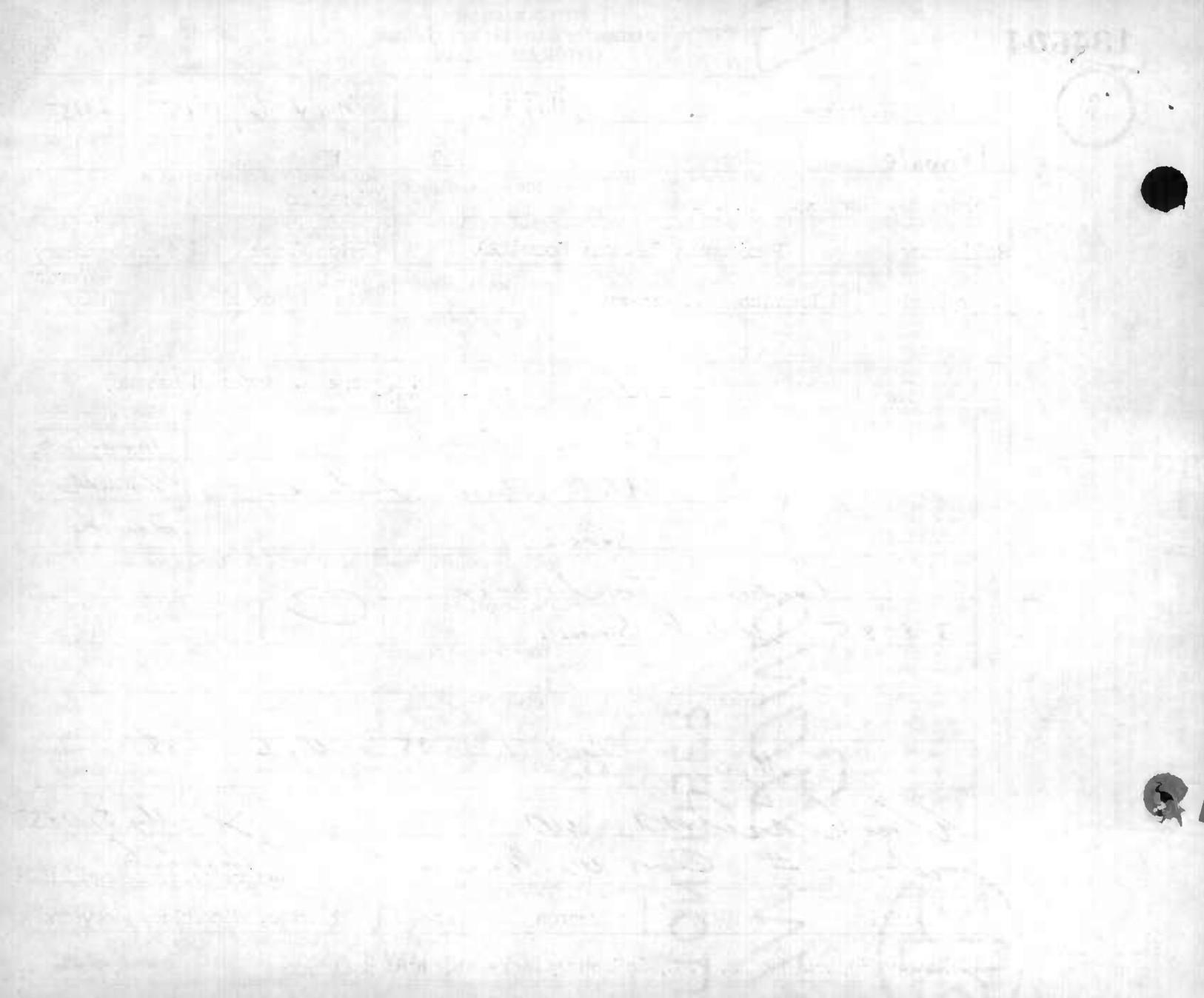
15592

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Gertrude				E.	Marks	Marks	May 6 1985	1	1	1985	2315 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS				
Female		White		MONTH	DAY	YEAR	61	IF UNDER 24 HRS MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Baltimore, Maryland		U.S.A.		Wicomico										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. WARDS			
Salisbury		Peninsula General Hospital			Office Clerk			Montgomery			21837			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Wicomico		Riverton			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rte #1 Box 117				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST				
Frank		Edward		Schroen			Mary			Martin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		214-20-1507			Mr. George A. Marks (Husband)			Same as #13e			immediate			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multisystem Failure</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia <i>Cardiac Insufficiency</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
3-8-85		Mild Stenosis					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)			22a. DATE SIGNED						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1985</i> , to <i>May 6, 1985</i> , that (I) (we) lost soul the deceased alive on <i>May 6, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Wayne E. Games, MD</i> DEGREE <i>MD</i>														
22c. DATE SIGNED		<i>May 5, 1985</i>		ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE	
Burial		5/10/1985		Riverton Cemetery			CITY OR TOWN Riverton, Wicomico, Maryland			STATE			<i>Laurel Pendell</i>	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Holloway Funeral Home, P.A., Salisbury, Maryland					MAY 10 1985									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the attending physician. Page 1 and 2 should be filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.



135653

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15593

REG. NO.

1. FOR  
STATE  
REGISTRAR

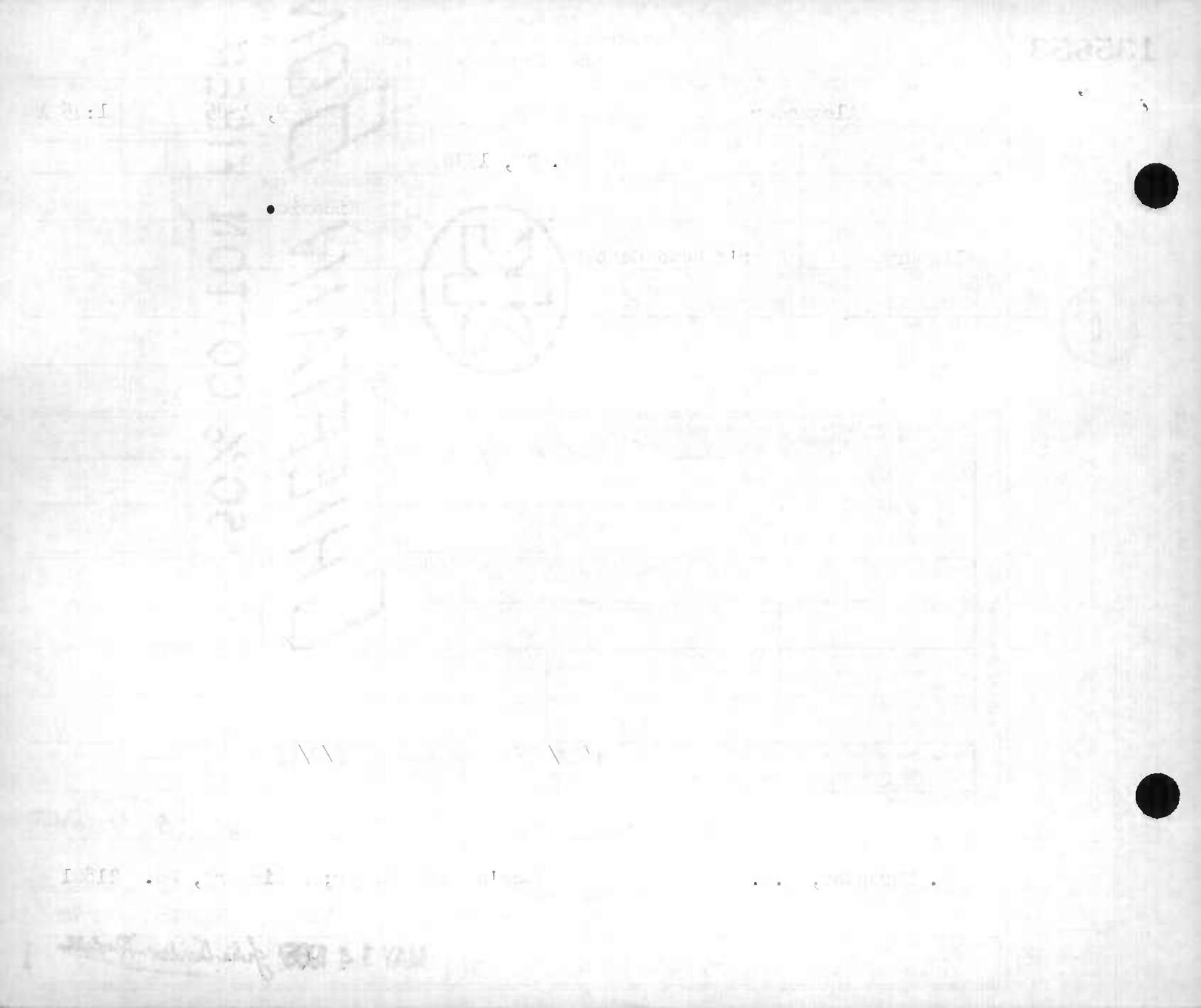
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Alexander MCALLISTER							May 9, 1985				1:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		Month Day Year Dec. 29, 1930			54		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Scotland		U.S.A.							Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Deer's Head Center					Bricklayer			MD.				
13a. STATE Maryland							13b. COUNTY Anne Arundel		13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 182 % Jack Daum	
14. FATHER'S NAME Patrick McAllister							15. MOTHER'S MAIDEN NAME Isabelle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No				Ursula Townsend (Deer's Head Center P.O. Box 2018 Salisbury, Md. 21801										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))							Carcinoma of Lung with metastasis							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 4/29/85 19 to 5/9/85 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED					
M. Shrestha			MD						5.9.85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Deer's Head Center; Salisbury, Md. 21801								
M. Shrestha, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION							
Cremation		5/9/1985		Salisbury Crematory			Salisbury, Wicomico, Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland														
25a. DATE REC'D. BY REG. DIR. 25b. REG. DIR. SIGNATURE MAY 14 1985 John J. Rendall														

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the offending physician and completed in full in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 12 &amp; 13 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, a medical examination must be made before certification.

BP \_\_\_\_\_



158053

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

reigned by the hospital or attending physician.

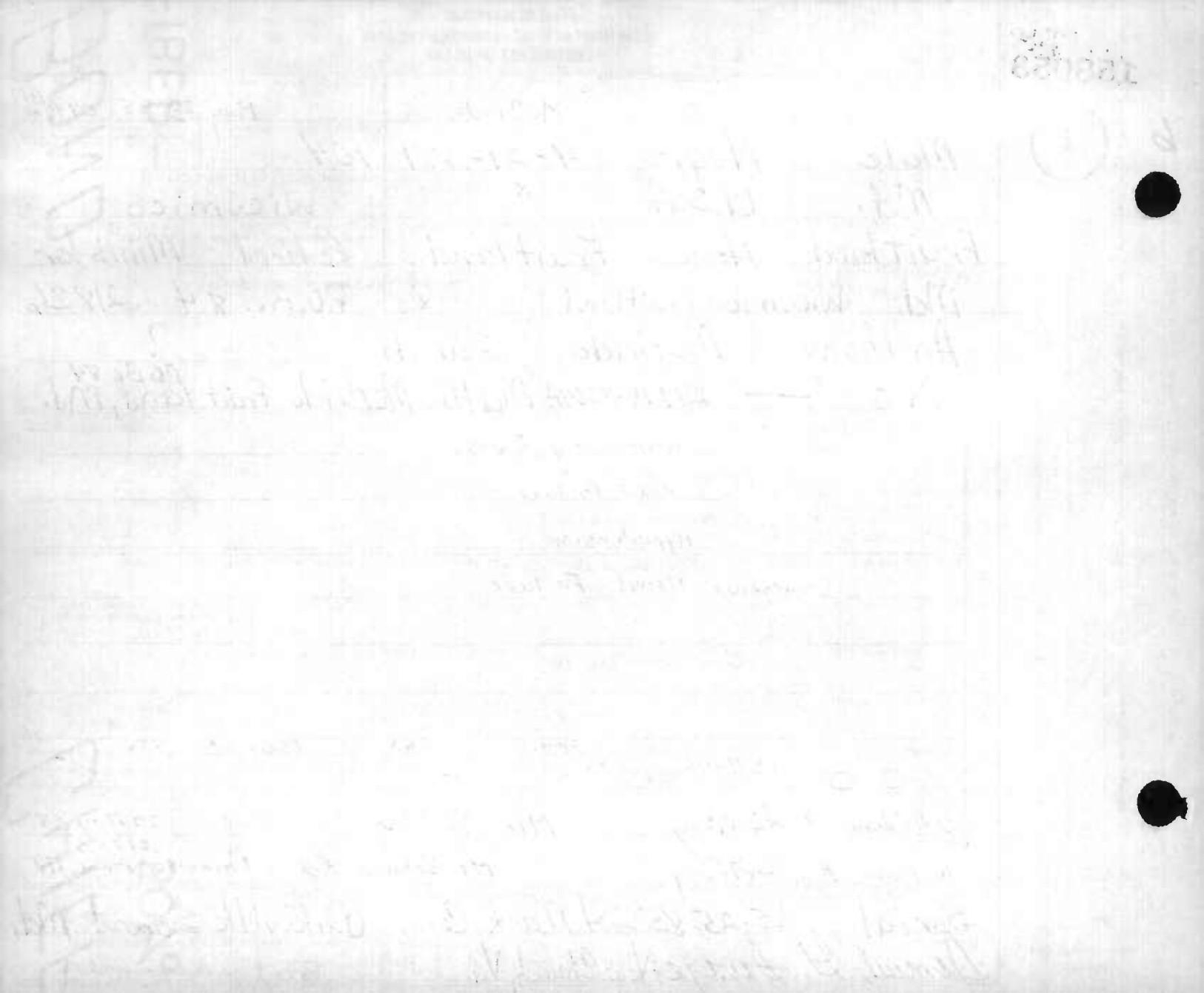
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										15594					
1 - FOR STATE REGISTRAR								REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
JOHN E McBride						May 20 85					AM 0740 AM				
3. SEX		4. RACE		5. NAME OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)									
Male		Negro		MONTH DAY YEAR		104									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.						Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Fruitland		Home - Fruitland		Retired		Minister									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Md.		Wicomico		Fruitland		YES		P.O.B. 84 21826							
14. FATHER'S NAME		FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Anthony				Sarah		217-14-8204A		Mattie McBride		P.O.B. 84					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		—													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Respiratory Arrest													
		DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure													
		DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Congestive Heart Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 1, 19 83, to May 19 85, that (I) (we) lost saw the deceased alive on 13 March 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED					
William A. Godfrey		MD		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		20 May 85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										21853			
William A. Godfrey		Mt Vernon Rd Princess Anne, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		5-25-85		St. Mark Cem.		Oaksville		Somerset		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Samuel G. Savage		New Church, Va.		JUN 5 1985		John Davidson Rendall									

22108



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												13577		15695	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
Marguerite Gordon Messick							May 9, 1985							4:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE [IN YEARS LAST BIRTHDAY]				IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		MONTH DAY YEAR			70				MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.				
Ohio		U.S.A.		04 20 1915			WICOMICO								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
SALISBURY		1934 PINEWAY		Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21801					
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		1934 Pineway							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						LAST (Unknown)				
Henry			Gordon		Mildred										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		291-10-9444A		Mr. Isaac Messick (Husband)		Same as #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Diabetes mellitus</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/6 19 80 to 5/9 19 85, that (I) (we) last saw the deceased alive on 5/8 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Robert J. Reilly</i>		DEGREE <i>ma</i>		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/10/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert J. Reilly</i>		22e. ADDRESS <i>Suite 614 Riverside Medical Park Riverside Dr., Salisbury, MD.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/1985		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens		23d. LOCATION CITY OR TOWN Hebron		COUNTY Wicomico	STATE Maryland						
24. FUNERAL DIRECTOR NAME <i>Holloway Funeral Home, P.A.</i>		ADDRESS <i>Salisbury, Maryland</i>		25a. DATE REC'D. BY REGISTRAR MAY 13 1985		25b. REGISTRAR'S SIGNATURE <i>Lia Lassiter Pendleton</i>									

7

1

137076-10  
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

10 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 5596			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 5-11- 1985							2b HOUR 1:40 A M			
1 DECEASED NAME (TYPE OR PRINT) JAMES LYNN MORRIS			5. DATE OF BIRTH MONTH DAY YEAR June 25, 1904							6. AGE (IN YEARS LAST BIRTHDAY) 80 IF UNDER 1 YEAR MONTHS DAYS			
3 SEX Male			4 RACE White		7b CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.		
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SALISBURY NURSING HOME							12a USUAL OCCUPATION Ret. Railroad		12b KIND OF BUSINESS OR INDUSTRY Auditor	
13a STATE Virginia			13b COUNTY Henrico		13c CITY OR TOWN Richmond			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2116 Winnwood Road			
14 FATHER'S NAME Caldwell James Morris			15. MOTHER'S MAIDEN NAME Edith Oliphant										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 719-01-1282							17 INFORMANT Irene M. Schultz ADDRESS 410 Pine Street Delmar, Md. 21875			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESTORATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CANCER PROSTATE													
DUE TO, OR AS A CONSEQUENCE OF (c) DEHYDRATION.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SENILE DEMENTIA.													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) 110/84							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 5/10/85 to 5/11/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b DATE SIGNED 5/15/85			
22b SIGNATURE William H. Robins			22c DEGREE MD							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. ROBINS, MD			22e ADDRESS										
23a BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b DATE 5-14-1985			23c NAME OF CEMETERY OR CREMATORIAL Smith Mills Cemetery			23d LOCATION CITY OR TOWN Delmar, Sussex County Delaware STATE				
24 FUNERAL DIRECTOR NAME Marvel-Short Funeral Home			25a DATE REC'D. BY REGISTRAR ADDRESS DeMar, Del. 19940							25b REGISTRAR'S SIGNATURE MAY 15 1985			

1



141077

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15591

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Clifford Gilbert MURPHY							MAY 9, 1985				1050M
1c. SEX <b>male</b>		1d. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>11</b> YEAR <b>1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS <b>YRS</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>self emp.</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>907 Roslyn Ave. 21613</b>			
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Edward</b> LAST <b>Murphy</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Bertha</b> MIDDLE <b>Olive</b> LAST <b>Jones</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2 220-10-6628</b>		17. INFORMANT <b>Bertha S. Murphy Item #13</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>- Ven. Thromb - Cardiac Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE (b) <i>Poor Cardiology</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Encephalitis</i> <i>for</i> <i>Paracanthal Wire Removal - Infection</i>											
19a. DATE OF OPERATION <b>5-9-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RETAINED INFECTED Paracanthal Wire</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>James W. Todd Jr.</i>								22c. DEGREE <b>MD</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NEVINS W. Todd Jr.</b>								22e. ADDRESS <b>Suite 25- Med Gr Wm. Palisancey Jr</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>5/11/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Dor. Memorial Pk.</b>		23d. LOCATION CITY OR TOWN <b>Cambridge</b>		COUNTY <b>Dor.</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>								25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1985</b>		25b. REGISTRAR'S SIGNATURE <i>St. David Rendell</i>	
ADDRESS <b>CAMBRIDGE MD.</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not, it may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

REMAINDER OF FORM TO BE FILLED IN BY THE ATTENDING PHYSICIAN  
After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

22011

22011 1970  
KODAK SAFETY FILM

22011 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Rule 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to the funeral director. Then please remove carbon papers. Please mark 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 2 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified before burial or removal.

151017

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15598

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Gladys Marshall NEAL</i>						<i>May 24/1985</i>				<i>10 50 M</i>			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS.				
<i>Female</i>	<i>White</i>	MONTH	DAY	YEAR	<i>73</i>	MONTHS	DAYS		HOURS	MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
<i>Md</i>	<i>V.S.A</i>					<i>Wicomico</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
<i>Salisbury</i>			<i>Peninsula General Hospital</i>			<i>Nurse Wk</i>					<i>Own home</i>		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
<i>Md</i>			<i>Wicomico</i>	<i>Nelson</i>				<i>101 E. Walnut 21830</i>					
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS	
<i>Jahr Westley Marshall</i>					<i>Ella Mae Smith</i>			<i>043-18-5609</i>			<i>Albert K. Neal, Nelson, Md</i>		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18d. IMMEDIATE CAUSE (a)			PART I. DEATH WAS CAUSED BY:	
<i>No</i>			<i>043-18-5609</i>			<i>3 days</i>			<i>Respiratory Failure</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive lung disease</i>			years							
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute bronchitis</i>			4 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
20. MEDICAL CERTIFICATION			21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (i) (this hospital) attended the deceased from <i>5/20</i> , 19 <i>85</i> , to <i>5/24</i> , 19 <i>85</i> , that (i) (we) last saw the deceased alive on <i>5/24</i> , 19 <i>85</i> , and that (i) (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			<i>5/24/85</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
<i>J.D. Meadous</i>			<i>560 Belmont Dr Bldg 2 Salisbury Md</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION			23e. COUNTY	
<i>Burial</i>			<i>5/20/85</i>			<i>Springhill Cemetery</i>			<i>Salisbury</i>			<i>Wicomico</i>	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<i>Colonel Wm. Ross Bravas, Md</i>									<i>MAY 28 1985</i>				

Wieder

zum ersten Mal  
seitdem ich hier  
lebe - und das ist  
etwa ein Jahr und  
halb - habe ich  
nur eine einzige  
Zeitung gesehen  
die mir gefallen hat  
und das war die  
"American  
Review of Books".  
Sie ist sehr gut  
ausgestattet mit  
kritischen Artikeln  
und es sind  
sehr viele  
Bücher besprochen.  
Ich habe sie  
sehr oft gelesen  
und ich kann  
sagen, dass sie  
eine sehr gute  
Zeitung ist.

O 20 1912 22 07

Die "American Review of Books" ist eine sehr gute  
Zeitung. Sie ist sehr gut ausgestattet mit kritischen  
Artikeln und es sind sehr viele Bücher besprochen.  
Ich habe sie sehr oft gelesen und ich kann sagen,  
dass sie eine sehr gute Zeitung ist.

141005

**1. FOR  
STATE  
REGISTRAR**

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5599

REF. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Thomas</i>	MIDDLE <i>NELSON</i>	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH DAY YEAR	2b. HOUR <i>4-28-85</i>							
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>12</i>	DAY <i>25</i>	YEAR <i>1906</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>78</i>	IF UNDER 1 YR. MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>	HOURS <i></i>	MIN. <i></i>	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR <i>5-1-85</i>		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>								
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1004 East Road</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>201 East Rd. Salisbury MD</i>								
14. FATHER'S NAME FIRST <i>Unknown</i>		MIDDLE <i></i>	LAST <i></i>	15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i>	MIDDLE <i></i>	LAST <i></i>	ADDRESS <i>705 N. Washington Dr.</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>												16b. SOCIAL SECURITY NO. <i>213-18-5255A</i>	17. INFORMANT <i>Jennifer Robinson</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>												DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												(b) _____		
												(c) _____		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>St</i>												TITLE (SPECIFY) <i>M.D.</i>	DATE SIGNED <i>5-2-85</i>	
EXAMINER'S NAME (TYPE OR PRINT)		EARL L. ROYER, M.D.			MEDICAL EXAMINER <i>Deputy</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-4-85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>GREEN ACRES</i>			23d. LOCATION CITY OR TOWN <i>Salisbury</i>		COUNTY <i>Wicomico</i>	STATE <i>MD.</i>				
24. FUNERAL DIRECTOR NAME <i>Clinton Stewart</i>		ADDRESS <i>Salisbury, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 16 1985</i>					25b. REGISTRAR'S SIGNATURE <i>La Fairionne Pendleton</i>				

ZONDER

DAG 1 van 1901

X — X —

X

158040

F

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15600

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>ALLEN Franklin NUTTER</i>						5	30	85	7:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Male</i>		<i>Black</i>		<i>8-30-1928</i>	DAY	<i>56</i>	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>Md</i>		<i>VSA</i>						<i>Wicomico</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Salisbury</i>		<i>Peninsula General Hospital</i>		<i>Waiter</i>		<i>Waiter</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE			
<i>Md</i>		<i>Wicomico</i>		<i>Jesterville</i>				<i>Box 45A</i>		<i>21814</i>	
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME							
<i>Norman</i>		<i>Nutter</i>		<i>Hettie Wallace</i>							
16a. WAS RELEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>Yes</i>		<i>113-22-4914</i>		<i>France = Nutter, Jesterville, NY</i>				<i>days</i>			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Hypoxic Encyclohalothalylly</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Cardiac Arrest</i>											
(b) <i>Chronic Congestive Heart Failure</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Congestive Heart Failure</i>											
(c) <i>Mins</i>											
Montes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>status Post Mitral Valve Replacement</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>5/17/85</i> to <i>5/30/85</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>5/20/85</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>Arnold M. Wood</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>5/30/85</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. M. Wood, MD</i>		22g. ADDRESS <i>644MC</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>6/6/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Jesterville Cem.</i>		23d. LOCATION FOR TOWN <i>Jesterville, MD</i>		23e. COUNTY <i>Wicomico, MD</i>		23f. STATE	
24. FUNERAL DIRECTOR <i>Cal J. Smith, Bivalve, MD</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

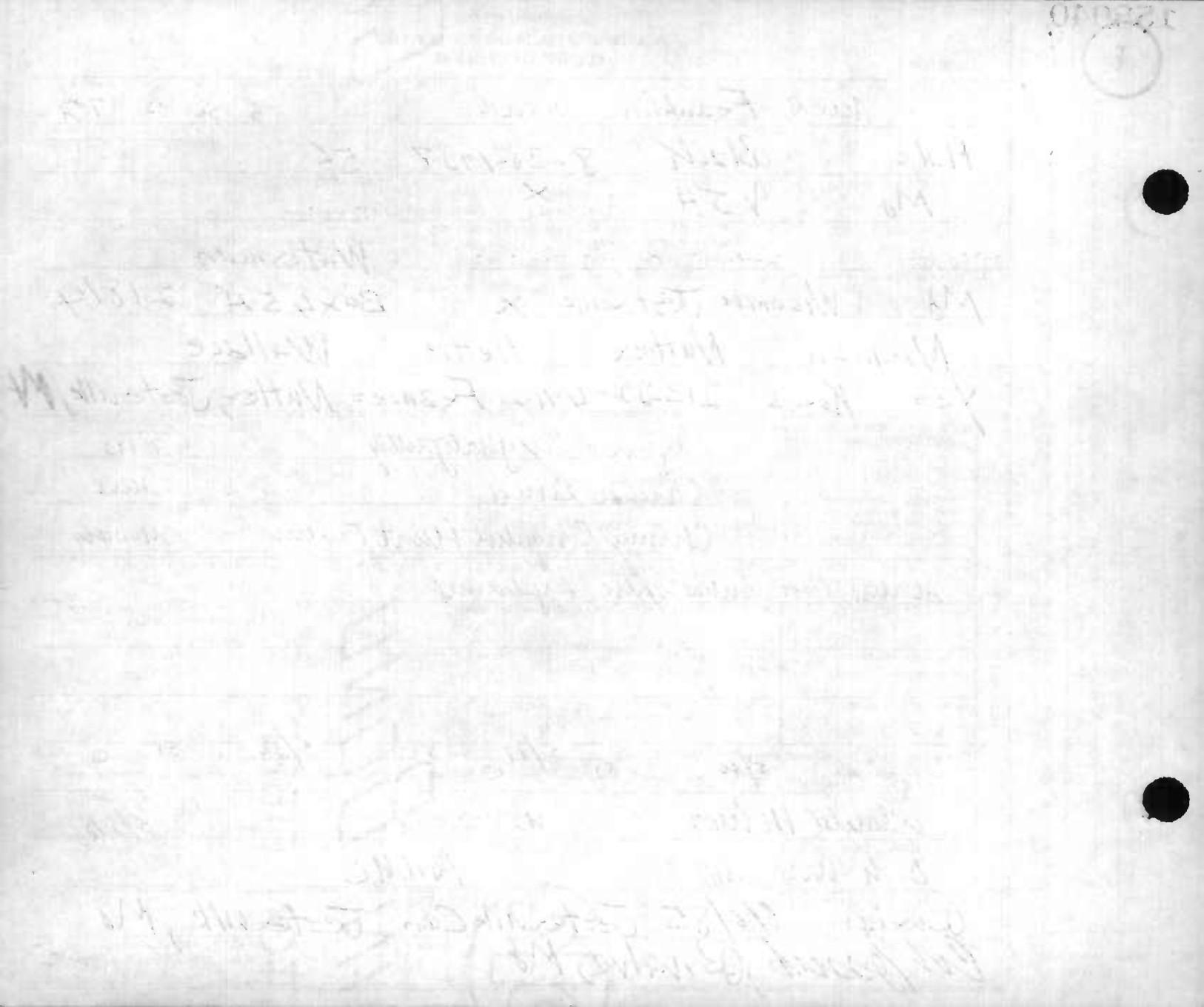
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP \_\_\_\_\_  
DHMH - 16 50M 4/83  
(VRA 15, 4)

Q5222



158110

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be qualified to be called.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<u>A. FREDERICK A. OLSEN</u>						<u>5-27-85</u>				<u>5:45A M</u>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
<u>MALE</u>		<u>WHITE</u>		MONTH	DAY	YEAR	<u>91</u>	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<u>Norway</u>		<u>U.S.A.</u>				<u>WICOMICO COUNTY</u>				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
<u>SALISBURY, MD.</u>		<u>SALISBURY NURSING HOME</u>				<u>Tutoring, Reviewer, U.S. Court.</u>				<u>21801</u>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		ZIP CODE	
<u>Maryland</u>		<u>Wicomico</u>		<u>Salisbury</u>				<u>303 Newfield Dr.</u>		<u>21801</u>	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		16. HENDRIKSON			
<u>HANS</u>			<u>Olson</u>	<u>ANNA</u>				<u>303 Newfield Dr.</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH			
<u>No</u>		<u>180-34-5826</u>		<u>Albert F. Olsen</u>		<u>303 Newfield Dr.</u>		<u>3 days</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (We) attended the deceased from <u>9/19/79</u> to <u>5/27/87</u> , that (I) (we) last saw the deceased alive on <u>5/26/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We declare (I) did not visit the body after death.)											
22b. SIGNATURE <u>DR. EARL M. BEARDSLEY</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>5/27/85</u>											
22c. ADDRESS <u>CIVIC AVE AT RT. 50, SALISBURY, MD. 21801</u>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
<u>Cremation</u>		<u>5/29/85</u>		<u>Bethesda Crematory</u>		<u>Levittown</u>		<u>Decatur</u>			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE					
<u>Baker &amp; Bounds, Salisbury, Md.</u>						<u>MAY 31 1985</u>					

QF 1971



151037

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15602

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
Theodore R. PALMER							MAY 22, 1985				125 M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS AT BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
M		BLK		MONTH	DAY	YEAR	82				YRS.		125 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
EXMOYR VA		USA					Wicomico				LABORER				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General Hospital		LABORER				Retired							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		ZIP CODE					
Md.		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		477 Robinson St.		21801					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO				17. INFORMANT			
Benjamin				Palmer		Cecilia		218-01-8722				Irene Cornish			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. IF YES, GIVE WAR OR DATES		16c. ADDRESS				16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				RT #1 Box 333											
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE				DUE TO, OR AS A CONSEQUENCE OF (c)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Chronic obstructive pulmonary Disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. LOCATION STREET CITY OR TOWN COUNTY STATE							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)													
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE <i>William B. Furdow</i>				22c. DATE SIGNED 5/23/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Mt Vernon Rd. Princess Anne Md. 21853				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE 5-25-85		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill M.G.		23d. LOCATION Hebron Wic. Md.		25a. DATE REC'D. BY REGISTRAR MAY 28 1985				25b. REGISTRAR'S SIGNATURE <i>Wardson-Gardner</i>			
24. FUNERAL DIRECTOR NAME Volley Mem. Chapel.		ADDRESS SALISBURY													
BP _____															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, an other traumatic event, the medical examiner must be notified of same.

SEARCHED



134540

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN 1 PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5603											
1. FOR STATE REGISTRAR		2a DATE KNOWN OF ESTI- DEATH MATED										2b HOUR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST				DATE	MONTH	DAY	YEAR								
ALINE		WILKINS						PARSONS				5-7-85			1623								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d HOUR				
Female		White		10 19 10			74 yrs.			MONTHS		DAYS		HOURS		MIN.		5-7-85			1623		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.										<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Wicomico			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Rt. 1, Smith Road										housewife				own home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS													
Md.		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt. 1, Smith Road													
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME															
		William		Thomas		Wilkins		Eva				Elliot											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT (son) ADDRESS											
no		214-36-5505										H. Edward Parsons, same As #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Arteriosclerotic Cardiovascular Disease years																							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																							
{ DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		HOUR A.M.		MONTH		DAY		YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion											
ACTUAL SIGNATURE												TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												DATE SIGNED 5-9-85											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM										23d. LOCATION CITY OR TOWN		COUNTY	STATE						
burial		5-10-85		Parsons Cemetery										Salisbury		Wicomico	Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS										25. REG'D. REC'D. YEAR		25. REGISTER'S SIGNATURE									
Baker-Bounds,		Salisbury, Md.										MAY 13 1985		John Baker-Bounds									
BP _____																							
DHMH - 17 (VR A15 ME (5))																							
20M 4/82																							



2001-03

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, 201 W. THIRTEEN-STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR  
1 - STATE  
REGISTRATION

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5504  
REG. NO.

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2d HOUR	
HERMAN William PARSONS, Sr.						<input checked="" type="checkbox"/>	5-29-85			1610	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	02 16 1914	71			5-29-85				1610	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Salisbury, Maryland		U.S.A.					Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital			Welder		21801				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland	Wicomico	Salisbury			Route #8 Box 528 Forest Plains						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
George William Parsons			Flossie Ellen Russ								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADRESSES		
No			220-10-9768			Mrs. Margaret C. Parsons (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Coronary Occlusion minutes											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.											
(b) Arteriosclerotic Heart Disease years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John T. Bulkeley</u> M.D. Deputy MEDICAL EXAMINER											DATE SIGNED 5-30-85
EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D. ADDRESS Pine Bluff Road, Salisbury, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY			STATE
Burial		6/1/1985		Springhill Memory Gardens		Hebron		Wicomico			Maryland
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland ADDRESS											25a. DATE REC'D. BY REGISTRAR
											25b. REGISTRAR'S SIGNATURE

oak tree - A large tree  
with a thick trunk and spreading branches.  
The bark is rough and greyish brown.  
The leaves are large and oval-shaped, with serrated edges.

over 100 years old.

PEAKS: Three distinct peaks are visible.

The highest peak is located in the center.

The second highest peak is located on the left.

The third highest peak is located on the right.

The peaks are covered in dense forest.

The terrain is rugged and rocky.

The sky is clear and blue.

The overall scene is peaceful and serene.

The landscape is a mix of natural beauty and man-made structures.

The buildings are mostly made of wood and stone.

The roads are dirt and rocky.

The waterfalls are located in the center of the valley.

The waterfalls are very tall and powerful.

The waterfalls are surrounded by lush green vegetation.

The waterfalls are a major attraction for tourists.

The waterfalls are a natural wonder of the world.

The waterfalls are a must-see destination for anyone visiting the area.

The waterfalls are a reminder of the beauty and power of nature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Please do not delay.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 2 and 3 should be detached for us as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 2 weeks after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

142075

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15605

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Florence D.</i>					<i>Phillips</i>	<i>May 12, 1985</i>				<i>0059</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
<i>Female</i>			<i>White</i>			<i>5-17-1903</i>			<i>82</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
<i>Md</i>			<i>U.S.A</i>						<i>Wilomino</i>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>53106bx</i>			<i>Peninsula Gen. Hospital</i>			<i>Unemployed</i>			<i>91858</i>		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
<i>Md</i>			<i>Wilomino Quantico</i>						<i>91858</i>		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>W. Jordan</i>			<i>Dan</i>	<i>dy</i>		<i>Jessie Elizabeth Ramey</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
<i>No</i>			<i>212-10-2684</i>			<i>Dianne Mitchell, Hebrew, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			<i>Congestive heart failure</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
<i>—</i>			<i>—</i>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>5/16/85</i> , to <i>5/16/85</i> , that (I) (we) last saw the deceased alive on <i>5/16/85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did/did not view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<i>J. A. Cockey, MD</i>						<i>318 Newton Rd</i>			<i>5/17/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			23c. ADDRESS								
<i>J. A. Cockey, MD</i>			<i>Baltimore, MD 21201</i>								
23a. BURIAL, Cremation, Removal (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		
<i>Burial</i>			<i>5/19/85</i>			<i>Quantico Cem.</i>			<i>Quantico, Md</i>		
24. FUNERAL DIRECTOR  <i>University Bivite, MD</i>						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						<i>MAY 20 1985</i>			<i>John Anderson</i>		

average

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached for use as the burial or funeral permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death.

144082

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15600  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Leon John POLEK						MAY 10, 1985				0104 AM			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR				
MALE		WHITE	MONTH	DAY	YEAR	59	IF UNDER 24 HRS						
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital			Manager Rev			Internal Rev.					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						14. STATE Maryland							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS / ZIP CODE			
Maryland		Wicomico		Hebron		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Ida		21830 Rockhawkin Rd.			
14. FATHER'S NAME FIRST		MIDDLE		LAST									
John		Frank		Polok									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes		WWII		215-24-7320		Ann V. Polok, Same as 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)  DUE TO, OR AS A CONSEQUENCE OF  (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Diabetes mellitus													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/10/85 to 5/10/85, that (we) last saw the deceased alive on 5/10/85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.													
22b. SIGNATURE J. Z. Martin						DEGREE M.D.							
22c. DATE SIGNED 5/11/85													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Martin, M.D.		22e. ADDRESS 1300 S. Division St., Salisbury, MD.											
23a. BURIAL, CREMATION, REMOVAL (CITY)		23b. DATE 5/12/1985		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Mem. Cde. Cemetery		23d. LOCATION CITY OR TOWN Hebron		23e. COUNTY		STATE Md.			
24. FUNERAL DIRECTOR John J. Borko													
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE Julia Davidson, Director							
MAY 21 1985													

1  
SCOTT

2006 white head

SCOTT

2006 white head

143023

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH15607  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2 RETAIN PAGES 5-8 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>CATHERINE</b>	MIDDLE <b>Minor</b>	LAST <b>POPE</b>	7a. DATE KNOWN OF DEATH ESTI- MATED	MONTH 5	DAY 13	YEAR 85	2d HOUR A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH 9	DAY 14	YEAR 14	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	
Female	White									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2021 S. Park Drive Extended</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS <b>21801 2021 S. Park Dr. Extended</b>				
14. FATHER'S NAME FIRST <b>Franklin</b>		MIDDLE -----	LAST <b>Minor</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>		MIDDLE <b>Elizabeth</b>	Jester			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. <b>219-05-3368</b>		17. INFORMANT		ADDRESS <b>Michael G. Pope, See Sec 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
21a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21g. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Actual Signature EXAMINER'S NAME (TYPE OR PRINT)		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							and in my opinion	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-16-1985</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Wicomico Mem. Park</b>		23d. LOCATION <b>Salisbury</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>			DATE SIGNED <b>5-13-85</b>
24. FUNERAL DIRECTOR NAME <b>Baker-Bounds, Salisbury, Md.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julie Wilson-Royer</b>				
DHMH - 17 (VR A15 ME (5)) 20M 4/82										

670502

2000 1000 1-

del 1000

decreto decretos decretos decretos decretos

decreto decretos decretos decretos decretos

decretos decretos decretos decretos

decretos decretos decretos decretos decretos

decretos decretos decretos decretos decretos

entry

decretos decretos decretos decretos

decretos decretos decretos decretos

S

N

X

1000

1000 1000

1000 1000



AS I S YAM

137036

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15608

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>CHESTER</b>	MIDDLE <b>M.</b>	LAST <b>PURDY</b>	2a DATE OF DEATH MONTH DAY YEAR	2b. HOUR <b>MAY 10, 1985 0744 M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6-15-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nuclear</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>WOR</b>		13c. CITY OR TOWN <b>BERLIN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3 CANAL - 21811</b>
14. FATHER'S NAME FIRST <b>ARTHUR</b>		MIDDLE <b>PURDY</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>PAULINE</b>		MIDDLE <b>VOGEL</b>	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>104-16-4566</b>		17. INFORMANT ADDRESS <b>F.H. PURDY BERLIN, MD.</b>				
<b>II CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PANCREATO DUODENECTOMY</b> 5-16-85 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (c) <b>Amplillary CARCINOMA c local metastases</b>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>PROSTATE Ca</b>								
19a. DATE OF OPERATION <b>5/16/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ampullotomy CARCINOMA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/16/85</b> , 19, to <b>5/10</b> , 19, <b>85</b> , that (I) (we) lost sow the deceased alive on <b>5/10/85</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.								
22b. SIGNATURE <b>Howard L. Crawshaw</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/10/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CRAWSHAW</b>		22e. ADDRESS <b>317 MED. CTZ SALISBURY MD 21801</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>5/12/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>SUNSET M.P.</b>		23d. LOCATION TOWN CITY COUNTY <b>BERLIN, WOR, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>ULLRICH F.H. BERLIN, MD.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>MAY 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jeanne Dawson Pendleton</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be informed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use at the burial/memorial service. The please remove carbon paper. Page 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene either for burial, cremation, or removal.

IMPORTANT: If Item 21 is marked with an "X" (any injury, any injury, or other traumatic event, the medical examiner shall be notified and advised).

EX-1001



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page may be continued by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, postpaid envelope (Form 10) and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15609												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR				2b. HOUR												
Raymond			E.		RAYNE	May 10, 1985				3 A M												
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Male			White		April 15, 1905		80 YRS				MONTHS DAYS		HOURS MIN.									
7. BIRTHPLACE COUNTRY			8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Maryland			USA		Wicomico		Salisbury				Deer's Head Center				Farmer				Agr.			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				21813							
Maryland			Worcester		Bishopville						Box 333 Main Street											
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE		LAST										
Issac			E.		Rayne	Elia				M.		Hudson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No			214-30-7984		Denny Rayne, Bishopville, MD																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ZSRD</u> <u>ESRD</u>																						
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>cerebral vascular insufficiency</u>																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED P.M. 19		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21e. LOCATION STREET				CITY OR TOWN		COUNTY STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>85</u> , to <u>5-10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>5-10-85</u>												
22b. SIGNATURE <u>Kyung Yoon, M.D.</u> DEGREE										22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>												
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kyung Ook, Yoon, M.D.</u>										22f. ADDRESS <u>Deer's Head Center, Salisbury, Md. 21801</u>												
23a. BURIAL, Cremation, Removal (TYPE OR PRINT)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN				23e. COUNTY				23f. STATE							
Burial			5-12-85		Bishopville		Bishopville				Worcester				MD							
24. FUNERAL DIRECTOR NAME			ADDRESS <u>Deer's Head Center, Salisbury, MD</u>				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>Gilia Davidson-Pendall</u>											
							MAY 13 1985															



LIBRARY

NEW YORK PUBLIC LIBRARY

500 Madison Avenue

New York City

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

162017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15610						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
FRANCES RHODES						May 27, 1985						2:30 pm				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Caucasian		MONTH 08 DAY 01 YEAR 1901			83			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Wicomico County MD.					
New York			U.S.A.													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury			Deer's Head Center					piano teacher same								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS / ZIP CODE						
13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City			Rt. 1, Box 283, 21842								
14. FATHER'S NAME FIRST Saverio			MIDDLE		15. MOTHER'S MAIDEN NAME LAST Angelina			MIDDLE			LAST Castagna					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			086-28-7290		Rosalie M. Rossi, Ocean City, MD 21842											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<i>respiratory Failure</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe COPD &amp; cor pulmonale</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i> .																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3, 1985, to May 27, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 27, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>M. Shrestha</i>			DEGREE M.D.						ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5.27.85.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, MD. 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/1/85			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Pk			23d. LOCATION Berlin			CITY OR TOWN County State Worcester MD				
24. FUNERAL DIRECTOR NAME W. Kirk Burbage, 108 Wms. St., Berlin, MD			25a. DATE REC'D. BY REGISTRAR JUN 7 1985											25b. REGISTRAR'S SIGNATURE <i>Judith Davidson-Payette</i>		



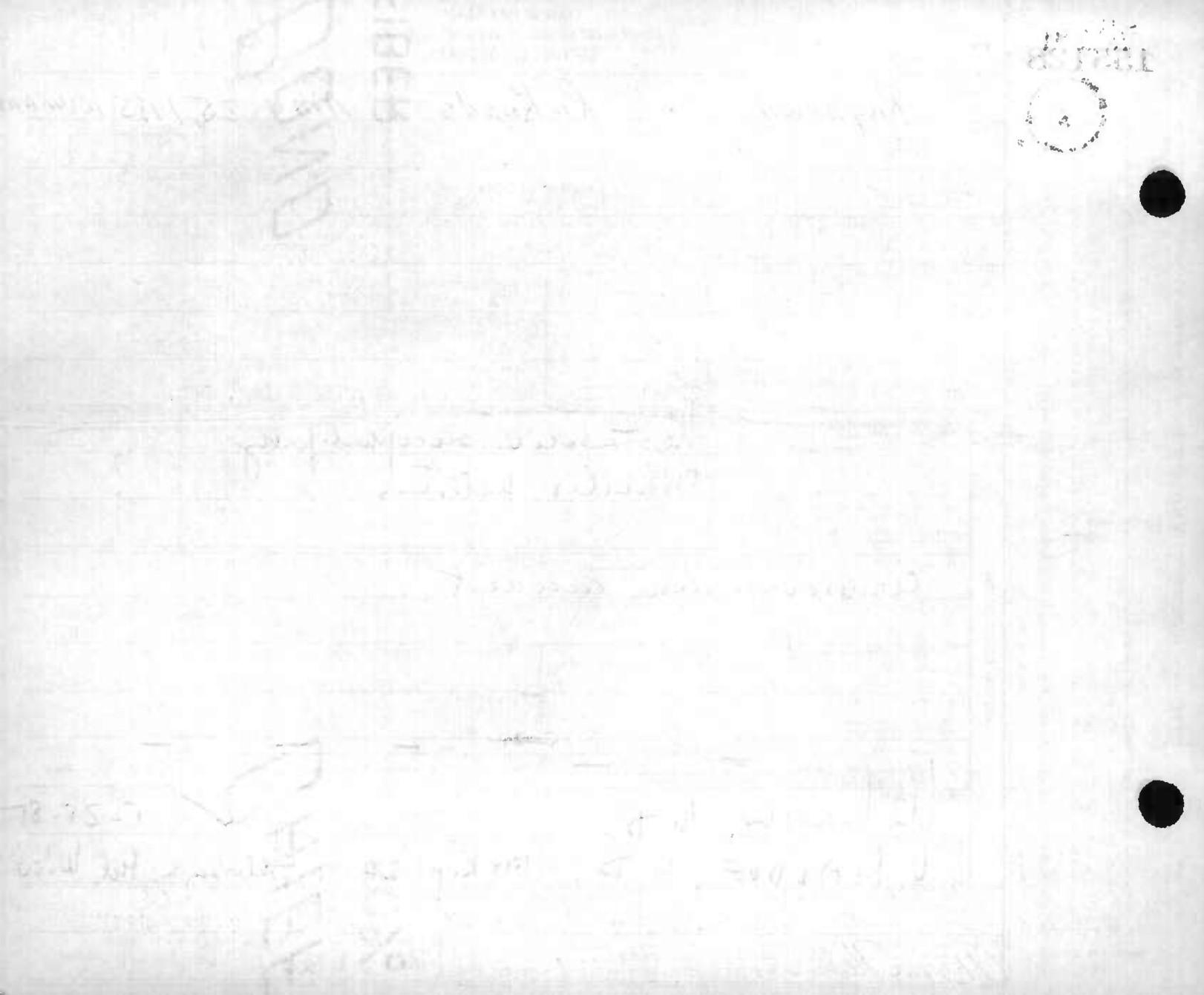
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15611		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Raymond			H.	Rickards		May 25, 1985						10:40 AM		
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
				MARCH 4, 1896			89			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
DELAWARE			USA											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
SALISBURY			WICOMICO NURSING HOME			(R) FARMER								
13a. STATE DELAWARE			13b. COUNTY SUSSEX			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE HONOLULU ROAD 99999					
14. FATHER'S NAME LUTHER			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME MARY			MIDDLE	LAST	RICKARDS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT MARGARET LYNCH, SELBYVILLE, DEL.			ADDRESS					
NO			222-05-7738											
18. CAUSE OF DEATH (Enter only one cause per line for part 1a and 1b) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metabolic encephalopathy</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metabolic ketoacidosis</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i></i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebrovascular accident.</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> , to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>L. J. Mallove, M.D.</i>			22c. DEGREE <i></i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED <i>1-25-85</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. J. Mallove M.D.</i>			22g. ADDRESS <i>1814 Kipling Dr. Salisbury, Del. Wicco</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 28, 1985			23c. NAME OF CEMETERY OR CREMATORIAL CAREY'S CEMETERY			23d. LOCATION CITY OR TOWN FRANKFORD SUSSEX DELAWARE			COUNTY		STATE
24. FUNERAL DIRECTION <i>Franklin Funeral Svcs.</i>			25a. DATE REC'D. BY REGISTRAR MAY 31 1985			25b. REGISTRAR'S SIGNATURE <i>Sue Davidson-Randall</i>								
FRANKFORD, DE LAWARE 19945														



157078

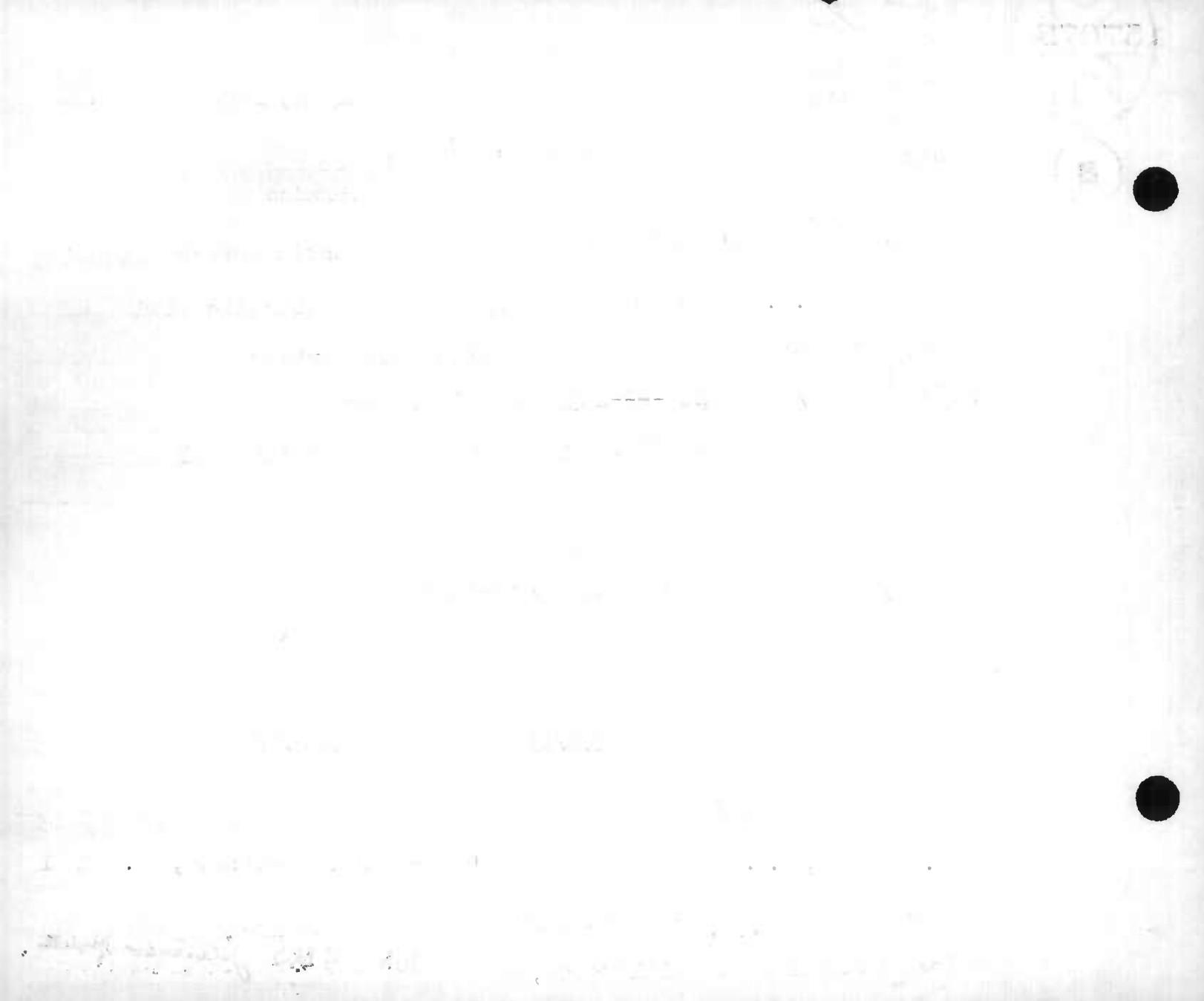
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15612

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth RINGGOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 27, 1985</b>	2b. HOUR 8:45P
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>July 15, 1916</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. M.D.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Deer's Head Center</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic worker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>	
13a. STATE <b>DE</b>	13c. CITY OR TOWN <b>New Castle</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>4 Monticello Blvd 99999</b>	
14. FATHER'S NAME FIRST <b>Raymond Ringgold</b>	MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth Christy</b>	MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A 222-09-1833</b>	17. INFORMANT <b>Jennie Johnson</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive CVA in coma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>large decubitus ulcers</b>				
19a. DATE OF OPERATION <b>5/27/85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>NOT WHILE AT WORK</b>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>falling down</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET <b>Deer's Head Center</b>	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>3/1/85</b> , 19_____, to <b>5/27/85</b> , 19_____, that (I) (we) last saw the deceased alive on <b>3/1/85</b> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>M. Shrestha</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>5/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Shrestha, M.D.</b>	22e. ADDRESS <b>Deer's Head Center; Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/31/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Sassafras</b>	23d. LOCATION CITY OR TOWN <b>Sassafras</b>	COUNTY STATE <b>Kent MD</b>
24. FUNERAL DIRECTOR <b>Fellows Funeral Home</b>	ADDRESS <b>Millington, MD</b>	25a. DATE REC'D. BY REGISTRAR <b>JUN 04 1985</b>	25b. NAME <b>J. Shrestha</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Boxes 4 may be checked by the physician or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 2 should be detached for use as the burial/transit permit. Then please remove carbon slips. Pages 1 and 2 should be filed within 72 hours after death.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



144069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

retdained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolegal officer must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15613					
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
<i>Ruth Jones</i>						<i>Robert Jones</i>	<i>May 16 85</i>							<i>11:09 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>Black</i>		MONTH	DAY	YEAR	75				MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.				
<i>Md</i>		<i>VSA</i>		<i>2-12-1910</i>			<i>Wicomico</i>				<i>Wicomico</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
<i>Salisbury</i>		<i>Peninsula Gen. Hospital</i>		<i>House Wife</i>				<i>Own Home</i>							
13a. STATE		13b. COUNTY		12c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21814					
<i>Md</i>		<i>Wicomico</i>		<i>Jessup</i>		<i>NO</i>		<i>Box 16A</i>							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST						
<i>James N. Jones Jr.</i>					<i>Mary D. Taxco</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO UNKNOWN) (IF YES, GIVE WAR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
<i>No</i>		<i>214-12-5815</i>		<i>Lucille O. Nutter, Nanticoke, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSION</i> .															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>COPD RENAL FAILURE 30 TO ASCVD</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>5/16/85</i> , 19 <i>85</i> , to <i>5/16/85</i> , 19 <i>85</i> , that <input type="checkbox"/> (we) lost sow the deceased alive on <i>5/16/85</i> , 19 <i>85</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.															
27b. SIGNATURE <i>Dennis Chognelli M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/16/85</i>									
27e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dennis Chognelli MD</i>		22e. ADDRESS <i>521156ux, Md</i>													
23a. BURIAL, CREMATION, REMOVAL UP TO DATE		23b. DATE <i>5/15/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN <i>Jessup, Md.</i>		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Garrison-Randall</i>							

卷之三

157097

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION 320, VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

999999  
BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH1 5 6 1 4  
REG. NO.

1- STATE REGISTRAR		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2b HOUR									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DONALD		MIDDLE Degastas		LAST SHAW		5 18 1985 2213			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 2 DAY 28 YEAR 17		6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH 5 DAY 18 YEAR 1985 2225	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.				MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) Ship Building		12b. KIND OF BUSINESS (FOR MOST OF WORKING LIFE) Shipyard					
13a. STATE Virginia		13b. COUNTY Accomack		13c. CITY OR TOWN Chincoteague		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 305-15 23336 99999			
14. FATHER'S NAME FIRST John MIDDLE Shaw LAST		15. MOTHER'S MAIDEN NAME FIRST Blanch MIDDLE Taylor LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN? No		16b. SOCIAL SECURITY NO. 711-07-5126		17. INFORMANT ADDRESS Elodie Shaw, Chincoteague, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA AND ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) SEVERE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Years											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John T. Bulkeley</u>		TITLE (SPECIFY) M.D. DEPUTY		MEDICAL EXAMINER		DATE SIGNED 5/19/85					
EXAMINER'S NAME (TYPE OR PRINT) JOHN T. BULKELEY		ADDRESS SALISBURY, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL SPECIAL Burial		23b. DATE 5-22-85		23c. NAME OF CEMETERY OR CREMATORIAL Daisey Cemetery		23d. LOCATION CITY OR TOWN Chincoteague, Virginia COUNTY STATE					
24. FUNERAL DIRECTOR <u>George S. Selby</u>		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 28 1985		25b. REGISTRAR'S SIGNATURE <u>Julie Landon Pendell</u>					
DHMH - 17 (VR A15 ME (5)) 20M 4/82											

THURSDAY

LESS 2 81

LESS 3 81

LESS 4

LESS 5

LESS 6

LESS 7

LESS 8

LESS 9

CONTINUED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 1 AND 2 WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

143050

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15615  
REG. NO.

1 - STATE REGISTRAR		2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR										2b. HOUR							
		TAMMY			CAROL			SHIVES			5 19 1985		2330 M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR			
FEMALE		WHITE		7 25 68			16 yrs.			MONTHS DAYS		HOURS MIN		5 20 1985		0050 Q			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		U.S.A.														WICOMICO			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital										Student				21061			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			13e. STREET ADDRESS									
Maryland		A.A.		Glen Burnie						572 Nolview Ct.									
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME														
		William J. Shives			Patricia										Piaskowski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No					220-06-2068			William Shives			572 Nolview Ct.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  8129														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Instant					
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY?					
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  Head on auto - truck collision													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET U.S. 50 West of Mardela Springs, Wic., Md.													
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE  JOHN T. BULKELEY						TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS SALISBURY, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY							
Burial			5-24-85			Glen Haven Mem. Pk.			Glen Burnie			A.A. Md							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Raymond C. Fink			Glen Burnie, Md.			MAY 21 1985			Julia Davidson-Hendell										

10000

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

0000 00 00 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15616				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR P 8 M		
LURA WELLS SHOCKLEY						May 20, 1985								
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		white		Feb. 21 1909			76			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA					Wicomico			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Pittsville		At Home RFD		Housewife						21850				
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Pittsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
William Howard Wells						Mary Emma Farlow								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT Russell Shockley			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS ev D</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>			ADDRESS Pittsville, Md. 21850				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Pickwickian syndrome, chronic diarrhea due to radiation therapy</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>11-19-84</i> to <i>11-19-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 5/21/85				
22b. SIGNATURE <i>Frank Colligan</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Burial		23b. DATE 5/23/85		23c. NAME OF CEMETERY OR CREMATORIAL Farlow's Cemetery		23d. LOCATION CITY OR TOWN Pittsville, Md.		25a. DATE REC'D. BY REGISTRAR MAY 27 1985		25b. REGISTRAR'S SIGNATURE <i>Julie Gordon Pendleton</i>				
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		ADDRESS Chestertown, Md.												

KANGAROO



2130 JUNE 22 Russell spo

DEPT S YAM

144090

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be attached by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15617						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH				MONTH	DAY	YEAR	2b HOUR			
Marie Frances Shockley					SHOCKLEY	MAY 17 1985							1300 M			
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White	MONTH	DAY	YEAR	39				MONTHS	YEARS	MONTHS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Salisbury, Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			Peninsula General Hospital			Principal - Elementary School				99999 19720						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Delaware			New Castle	New Castle			YES <input type="checkbox"/> NO <input type="checkbox"/>		810 Basin Road							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST							
William Francis Shockley						Argenia			Dennis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			214-42-9630			Mrs. Argenia Shockley (Mother)			702 Buckingham Circle, Salisbury, Md. 21801							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC lung Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DO TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____																
DO TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) <input type="checkbox"/> attended the deceased from saw the deceased alive on 5/17 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.			22b. SIGNATURE Joseph A. Gresso			DEGREE MD			22c. DATE SIGNED 5/17/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 5/17/85							
Joseph A. Gresso			1300 S. Division St., Salisbury, Md. 21801													
23a. BURIAL, CREMATION, REMOVAL 15. SPECIFY Burial			23b. DATE 5/19/1985			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland							
24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland									25a. DATE REC'D. BY REGISTRAR MAY 21 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Bondoc			

000181



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial permit. Then please remove carbon copies. Form 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, this medical examiner shall be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15618

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR		
Iona Mae Smack							May		17	1985	11:00 AM		
1. SEX:		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		April 17, 1908			77						
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Maryland		U.S.A.					WICOMICO						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Deer's Head Center					Housewife						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury			Route #6 Marvil Road 21801						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Thomas		Webster Cora B. Bozman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No		214-42-9449		Mr. Harry T. Smack (Husband)			Same as #13e						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							Metastatic ca of liver					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b) Adeno carcinoma rectum						
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 4-19, 1985, to 5-17, 1985, that (I) (we) last saw the deceased alive on 5-17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED			
K. Yoon, M.D.										5-17-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Deer's Head Center, Salisbury, Md. 21801									
KYUNG OOK YOON M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		5/21/1985		Springhill Memory Gardens Hebron			Wicomico		Maryland				
24. FUNERAL DIRECTOR: NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Holloway Funeral Home, P.A., Salisbury, Maryland				MAY 21 1985		Julia Davidson Pendell							

RECEIVED  
LIBRARY OF CONGRESS  
JULY 1961

60-100000  
SERIALS LIB.

CONT'D

60-100000  
SERIALS LIB.

WILLIAM F. BROWN  
BOSTON PUBLIC LIBRARY

RECEIVED  
LIBRARY OF CONGRESS  
JULY 1961

141044

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

卷之六

REG NO

I. DECEASED NAME (TYPE OR PRINT) <b>Ella C. Smith</b>			MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR <b>May 10, 1985</b>	DAY	YEAR	2b. HOUR <b>90411 M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-16-1909</b>	6. AGE - (IN YEARS LAST BIRTHDAY) <b>76</b>			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>MI</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>						
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Our Home</b>			
13a. STATE <b>MD</b>	13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Nantucket</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>21840</b>					
14. FATHER'S NAME <b>Clém Housemann</b>	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME <b>Elsie H. Webster</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? IF UNKNOWN <b>No</b>	16b. SOCIAL SECURITY NO. <b>244-10-8817</b>	17. INFORMANT ADDRESS <b>William H. Smith, 521us6a-7/m</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Intestinal obstruction</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (i) this hospital attended the deceased from <b>5/10/85</b> to <b>5/10/85</b> , that (ii) (we) last saw the deceased alive on <b>5/10/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul R Fleury</b>			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>5/10/85</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul R Fleury</b>			22e. ADDRESS <b>560 Riverside Dr Salisbury MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Buried</b>	23b. DATE <b>5/13/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Turner Corp</b>	23d. LOCATION CITY OR TOWN <b>Nantucket, MI</b>	23e. COUNTY <b>Wicomico, MD</b>		23f. STATE			
24. FUNERAL DIRECTOR NAME <b>J.W. Webb, BIV &amp; Co., MA</b>	25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Gilia Davidson-Pender</b>					

DIVISION OF VITA RECORDS 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

**JTO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN. The

more than 24 hours other than a medical certificate be issued.

and the death certificate be executed within 24 hours after death. Those who

TO HOSPITAL OR ATTENDING PHYSICIAN. THE

DHMH - 16 60M 7/B4  
(VRA 15, 4)

LANDLADY



135636

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15620  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Irma Layfield					Stampone	MAY 9, 1985-			0342M <sup>+</sup>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		White		MONTH 08 DAY 21 YEAR 1912		MONTHS			DAYS		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Maryland		U.S.A.				Wicomico			Salisbury		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Peninsula General Hospital			Telephone Operator			Hospital			MD.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Somerset		Princess Anne		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route #1 Pruitt Lane 21853		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST Laudie James Claudis Layfield			FIRST Bertha		MIDDLE Grace		LAST Livingston				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			220-09-5090		Mr. J. Carroll Layfield (Brother)		119 Benjamin Avenue, Salisbury, Maryland 21801			unclear	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>closure of cerebral</i> DUE TO, OR AS A CONSEQUENCE OF <i>but causally related</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-28</u> , 19 <u>85</u> , to <u>5-7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wilbur O. Ellis</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-9-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilbur O. Ellis, M.D.		22e. ADDRESS		Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/11/1985		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens		23d. LOCATION CITY OR TOWN Hebron, Wicomico, Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 13 1985		25b. REGISTRAR'S SIGNATURE <i>Lillian Sanderson Rondell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be left with the hospital until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "NO", it shows any injury, or other traumatic event, the medical examiner should be notified.

2026.1



130581

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15621

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			CHARLES	W.	TAYLOR	MAY 2, 1985			2105P.M.		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White	MONTH	DAY	YEAR	77	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.	
Pennsylvania			USA				Wicomico			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Machine Operator			Electric Corp.		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Worcester	Ocean City				15 St. Louis Ave. 21842			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Joseph			-	-	Taylor	Lillie			Elias		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			175-10-4150			Mr. C. William Taylor Jr.			180 Nancy Ave. York, Pa. 17403		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____			CONGESTIVE HEART FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) ASCVD								
(c) _____			DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			CHRONIC OBSTRUCTIVE DISEASE ) RENAL FAILURE								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			COUNTY	STATE	
22a. I certify that (this hospital) attended the deceased from 6/2, 1985, to 6/2, 1985, that (we) lost saw the deceased alive on 6/2, 1985, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<i>Dr. Chodnicki M.D.</i>									07/10/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	May	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Removal/Burial			5/3/1985		Prospect Hill Cemetery	York,			York,	Pa.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
ULLRICH			F.H. BERKIN, MD			MAY 8 1985			<i>Jeanne J. Wilson - Pendleton</i>		
OKC/CS											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

182051

RENT  
COLLECTED



128671

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 3 FOR YOUR PERSONAL USE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES NINETEEN THROUGH TWENTY SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 6 2 2

REG. NO.

1. FOR STATE REGISTRAR			2. DATE KNOWN <input checked="" type="checkbox"/> EST. DEATH MATED <input type="checkbox"/> MONTH DAY YEAR												2d. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			5-1-85				1322				
Ralph			Irvin			Taylor														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR			2d. HOUR	
Male		White		11 10 1922			62 yrs.			MONTHS		DAYS		HOURS		5-1-85			1322	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Delmar, Maryland		U.S.A.														Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital												Truck Driver			218822		
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Eden			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Oak Ridge Trailer Park								
14. FATHER'S NAME FIRST Orlando			MIDDLE Coy			LAST Taylor			15. MOTHER'S MAIDEN NAME FIRST Mallie			MIDDLE Collins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-16-8757			16c. INFORMANT Mrs. Margie Wilkins Taylor (Wife) Same as #13e			ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) starting the under- lying cause lost.																				
(b) Arteriosclerotic Cardiovascular Disease															years					
(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE															TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)															DATE SIGNED 5/3/1985					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 5/5/1985			23c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery			23d. LOCATION CITY OR TOWN Powellville, Wicomico, Maryland			COUNTY		STATE						
24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland															25a. DATE REC'D. BY REGISTRAR MAY 6 1985					
															25b. REGISTRAR'S SIGNATURE Gilda Davidson-Pendall					

EX-1

animal

labeled *Leucostoma siliculosum* var.

positive

microfilaria

erry *Oncosis uncinata* *siliculosum* var.

positive

X X

X

— — — — —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be directed for use on the burial permit. Then please remove carbon paper. Register form 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, show any injury or other traumatic event that medical examination made the immediate cause of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15623					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR	
Thomas Wilmer							Tilghman		May		1		1985	2145 M	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH 08 DAY 29 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Parsonsburg, Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.								
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Marina								
13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #1		21842				
14. FATHER'S NAME Thomas			MIDDLE Arthur		LAST Tilghman		15. MOTHER'S MAIDEN NAME Marie		16. FIRST MIDDLE Meredith		LAST Perdue				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-32-7298		17. INFORMANT Mrs. Mary Lee Griffin Tilghman (Wife) Route #50 Box 307 Little Manor, Ocean City, Md.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermod Carcinoma Left Lung 2 months.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Pneumonia, Respiratory Failure.</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>85</u> , to <u>5-1</u> , 19 <u>85</u> , that (I/we) last saw the deceased alive on <u>5-1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.															
22b. SIGNATURE <u>Roger C. Merrill, M.D.</u>			22c. DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>5/3/85</u>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill, M.D.			22f. ADDRESS 100 Power Street, Salisbury, Maryland 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/4/1985		23c. NAME OF CEMETERY OR CREMATORIUM Parsonsburg Cemetery		23d. LOCATION CITY OR TOWN Parsonsburg, Wicomico, Maryland								
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland			25a. ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland		25b. DATE REC'D. BY REGISTRAR MAY 6 1985		25b. REGISTRAR'S SIGNATURE <u>Sylvia Davidson Perdue</u>								

273851

Strewn among rocks, small

shrub patches, mostly

2552 x 1000 feet, 8000

143118

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15824

REG. NO.

1 - FOR  
STATE  
REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 30 days after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Hazel					TOWNSEND	MAY 12, 1985			0604 M				
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		Black	Oct. 7, 1930			54							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		USA				Wicomico							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital											
13a STATE Virginia		13b COUNTY Accomack		13c CITY OR TOWN Horntown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE P.O. Box 62		99999			
14 FATHER'S NAME Willie Taylor						15 MOTHER'S MAIDEN NAME Myrtle Mason							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c		17 INFORMANT		ADDRESS					
no		220-26-1330				Leon Mason - P.O. Bx. 62-Horntown, Va.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Severe reaction to chemotherapy ? Schizophrenia (c) metastatic carcinoma - Breast													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Am. Renal failure, Anemia, Heart failure, Hypotension													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from 4/10/85 to 5/12/85, that (I) (we) last saw the deceased alive on 4/10/85, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b SIGNATURE <i>Hoggan</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	22c DATE SIGNED <i>5/14/85</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS								
23a BURIAL, CREMATION, REMOVAL SPECIFY		23b DATE 5-18-85		23c NAME OF CEMETERY OR CREMATORIAL Tabernacle			23d LOCATION CITY OR TOWN Horntown		COUNTY	STATE			
Burial									Accomack	Va.			
24 FUNERAL DIRECTOR NAME		25 DATE REC'D. BY REGISTRAR Accomac, Va. 23301			26 REGISTRAR'S SIGNATURE <i>Jude Davidson-Kendall</i>								

卷之三

143004

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15625

1 - STATE  
REGISTRAR

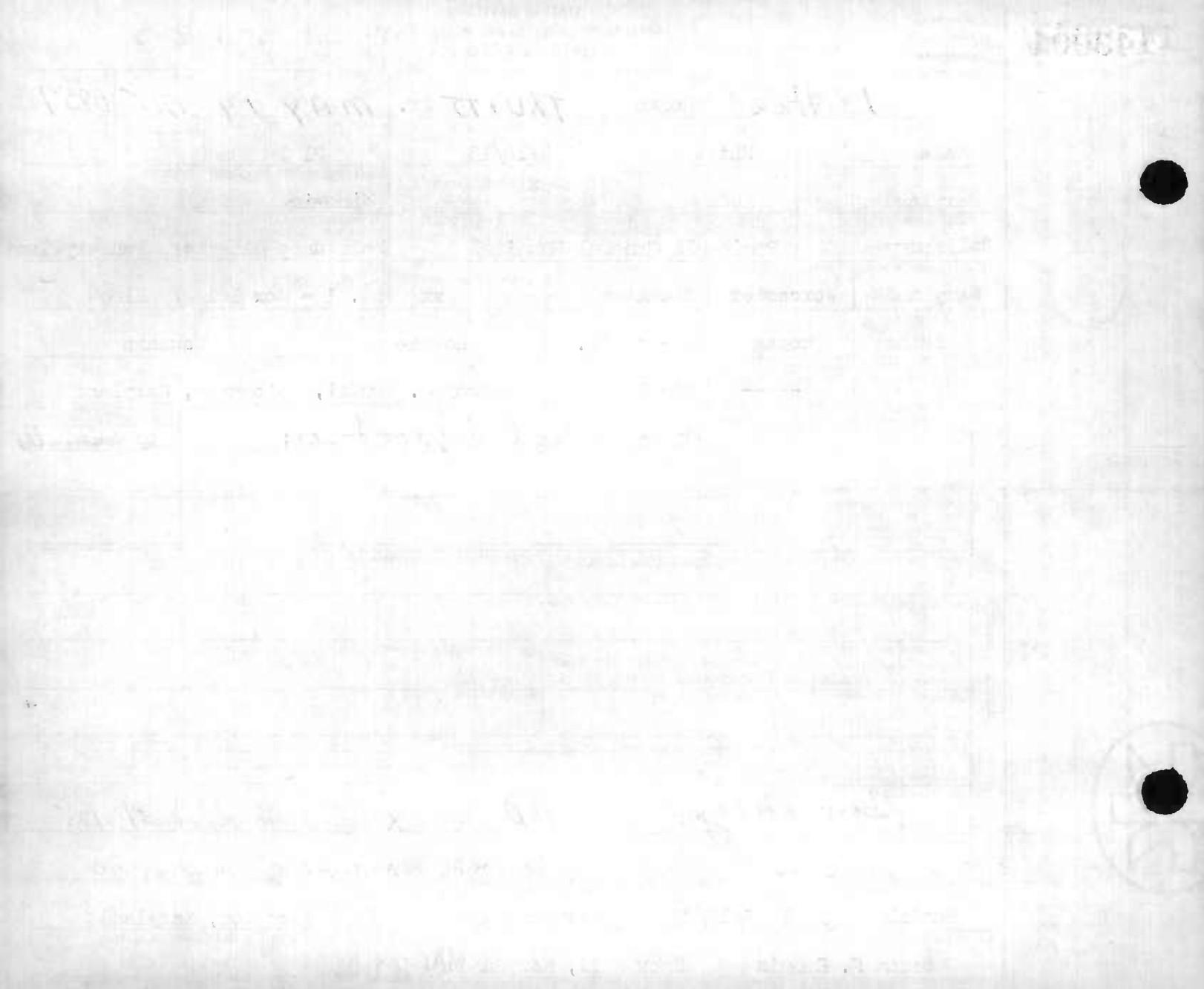
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, forward it to the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove the paperclips. Pages 1 and 2 should be left in place for removal.

IMPORTANT: If item 21 is marked as shown in item 18, show why injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR											
<i>Luther</i>			Thomas		TRUITT Jr.	MAY 14 1985				0857 M											
3. SEX		4. RACE		5. DATE OF BIRTH																	
Male		White		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		71	YRS.	MONTHS	DAYS	HOURS	MIN.								
Maryland		USA						9. BALTIMORE CITY OR COUNTY OF DEATH													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Salisbury		Peninsula General Hospital		Maintenance Director		Poultry Plant															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
Maryland		Worcester		Stockton		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rt. 1 - Box 101 / 21864													
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME																
		Luther	Thomas	Truitt Sr.	Lottie																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS															
No		-----		216 12 1496		Audrey J. Truitt, Stockton, Maryland															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF  (b)  (c)		DUE TO, OR AS A CONSEQUENCE OF  (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
myocardial infarction																30 minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
				YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>		NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>Ben Meyer</i>		22c. DEGREE <i>MP</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5/14/85															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BEN MEYER MD</i>		22e. ADDRESS <i>RIVERSIDE MEDICAL PARK, SALISBURY MD</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial 5/17/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Portersville</i>		23d. LOCATION CITY OR TOWN <i>Stockton, Maryland</i>															
24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis</i>		ADDRESS <i>Snow Hill, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 21 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Taylor</i>															



134603

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15626

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
<i>Rhoda L. Truitt</i>						<i>May 6 1985</i>				5:05AM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
<i>Female</i>		<i>WHITE</i>	MONTH	DAY	YEAR	<i>55</i>	MONTHS	YEARS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>WEST VIRGINIA</i>		<i>USA</i>				<i>WICOMICO</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>SALISBURY</i>		<i>PENINSULA GENERAL HOSPITAL</i>			<i>STOREKEEPER</i>			<i>RETAIL</i>			
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>WORCESTER</i>	13c. CITY OR TOWN <i>WHALEYSVILLE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>RT 1 Box 239 21872</i>				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>RUSSELL</i>			<i>LAMBERT</i>	<i>DAISEY</i>				<i>TERER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>220-26-3994</i>			17. INFORMANT			ADDRESS			
<i>NO</i>								<i>Norwood B. Truitt, Whaleyville, MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Ovary</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (he) (this hospital) attended the deceased from <i>2 May 1985</i> to <i>6 May 1985</i> , that (he) (we) last saw the deceased alive on <i>6 May 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <i>5/6/85</i>
22b. SIGNATURE <i>James E. Martin, M.D.</i>		22d. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James E. Martin, m.o.</i>		22f. ADDRESS <i>1300 S. Division St., Salisbury, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>5-7-85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>DALE CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>WHALEYSVILLE, WORCESTER, MD</i>					
24. FUNERAL DIRECTOR NAME <i>Barry W. Hastings, Hastings Funeral Home, Selbyville</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 10 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be signed by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Page 1 must be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called.

COPIED

Third in a row

Second time showing

Opposition from the people

and the armed forces have been given

the go-ahead to continue their

work.

On the other hand, the people

are continuing to support the

army and the armed forces

and they are continuing to work

on the basis of the principles

of democracy and freedom.

The people are continuing to support

the army and the armed forces

and they are continuing to work

on the basis of the principles

of democracy and freedom.

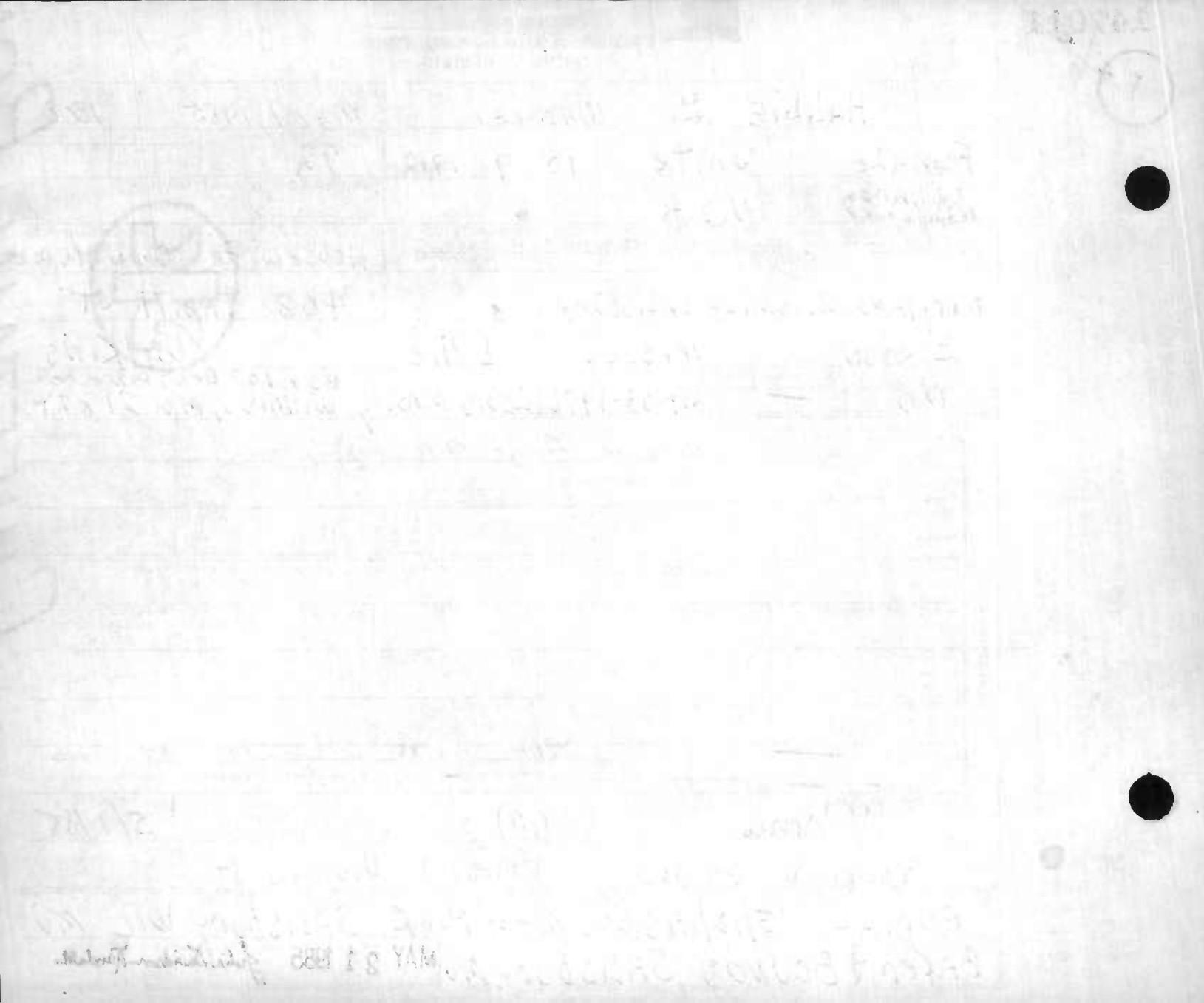
147011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15627			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
HALIE H. WADSLY						MAY 9, 1985			1800 M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
FEMALE		White		10 9 1912		72							
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Williamsburg MARYLAND		U.S.A.				Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF MEDICAL CENTER GIVING CARE)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General Hospital		Housewife		Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21801			
Maryland		Wicomico		Salisbury				408 Truitt St					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Gordon		Lillie Wilkins		No		814-03-1496		Louis Massey		Box 107 Bent Pine Rd. Williams, MD 21874			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Large Cell Lymphoma													
DO TO, OR AS A CONSEQUENCE OF (b)													
DO TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 5/9, 1985, to 5/9, 1985, that (I) (we) last saw the deceased alive on 5/9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) (had) (not) view the body after death.													
22b. SIGNATURE Joseph A. Grasso		DEGREE MM		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/9/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso		22e. ADDRESS 1300 S. Division St											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5/12/1985		23c. NAME OF CEMETERY OR CREMATORIAL Wic Mem Park		23d. LOCATION CITY OR TOWN Salisbury, Wic, MD							
24. FUNERAL DIRECTOR BAKER & BOUNDS SALISBURY, MD		ADDRESS		25. DATE REC'D. BY REGISTRAR MAY 21 1985		25. REGISTRAR'S SIGNATURE Julia Baker-Bounds							



142149

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15628

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST John	MIDDLE L.	LAST Wagner WAGNER	2a. DATE OF DEATH MONTH 05 DAY 11 YEAR 1908	MONTH MAY	DAY 15	YEAR 1985	2b. HOUR 116 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 05 DAY 11 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Construction		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #13 37th Street 21842	
14. FATHER'S NAME FIRST Frederick		MIDDLE	LAST Wagner	15. MOTHER'S MAIDEN NAME Ella				LAST Long	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 214-07-7094		17. INFORMANT Mr. James F. McCabe (Power of Attorney) PO Box 307 Showell, Maryland 21862		ADDRESS Showell, Maryland 21862			
18. CAUSE OF DEATH: Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adolescent Cardiopulmonary Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Precor myocardial infarction</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>5-15-85</u> to <u>5-15-85</u> , that (I) <input type="checkbox"/> saw the deceased alive on <u>5-15-85</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did/ did not view the body after death.									
22b. SIGNATURE <i>James F. McCabe</i>		DEGREE MA		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 5-15-85			
22d. PHYSICIAN'S NAME, TITLE OR PRINTS <i>James F. McCabe</i>		22e. ADDRESS Suite 12 Medical Center							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/1985		23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 20 1985		25b. REGISTRAR'S SIGNATURE <i>Judith Anderson Pendleton</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/memorial permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

old car

200.00 YAH.

158111

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 5 6 2 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

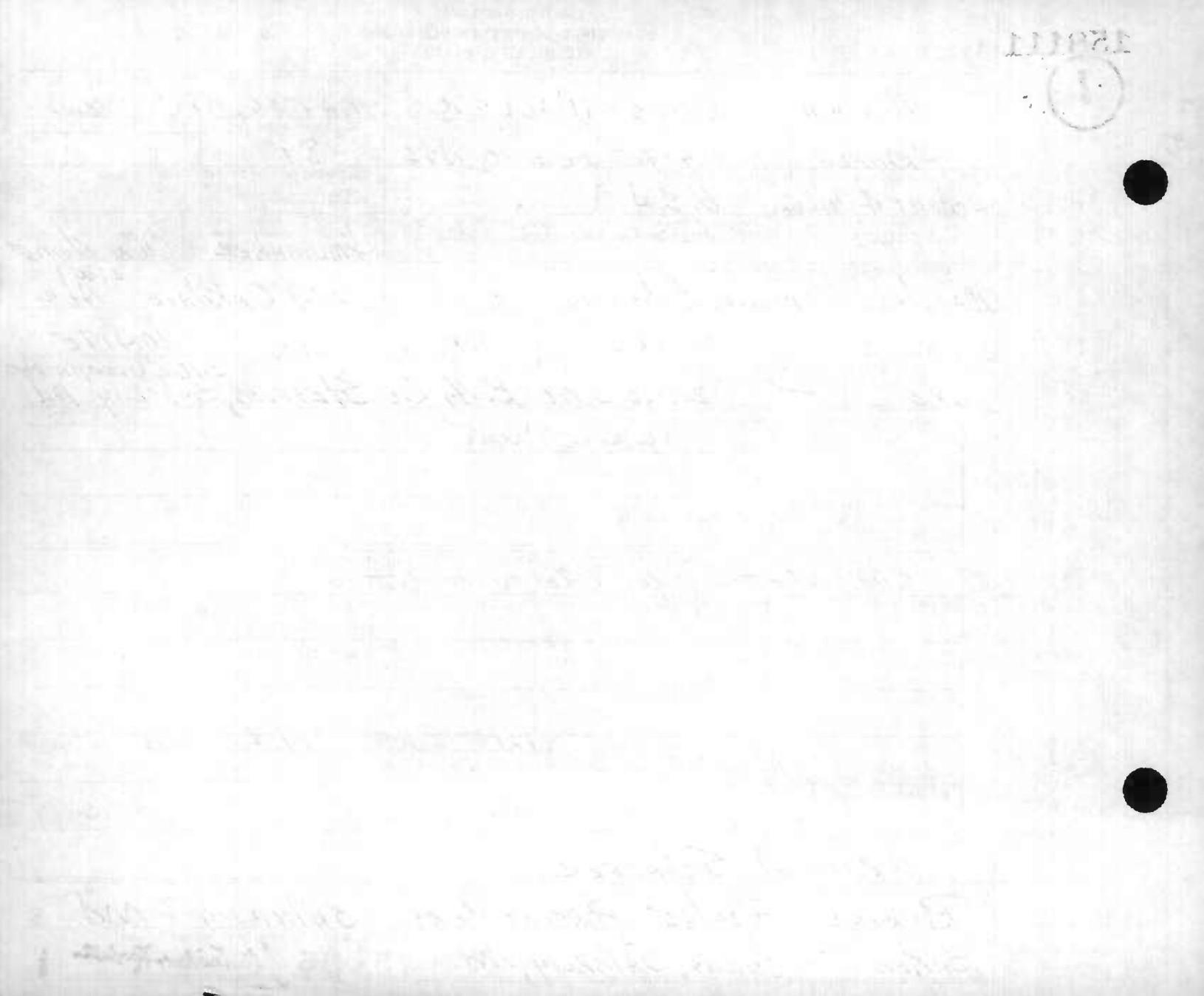
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Miriam EVANS WALLER</i>					<i>MAY 26, 1985</i>			0600 M			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
<i>FEMALE</i>		<i>WHITE</i>	<i>FEB 10, 1896</i>			<i>89</i>					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION <i>HOMEMAKER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>		13c. COUNTY <i>Armenia</i>		13d. CITY OR TOWN <i>Salisbury</i>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS ZIP CODE <i>229 Oakdale Ave 21811</i>			
14. FATHER'S NAME <i>FRANK</i>		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME <i>Mary Lou</i>		MIDDLE	LAST	16. ADDRESS <i>516 Georgia Ave, Salisbury, Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>217-10-3997</i>			17. INFORMANT <i>Betty Lou STEFFENS</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)									
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
<i>SIP collection for colovescicle fistula</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/29</i> , 19 <i>85</i> , to <i>5/26</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>5/25</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>CRraig Schaefer</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>5/26/85</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Craig Schaefer</i>		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>5/29/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parsons Cem.</i>			23d. LOCATION CITY OR TOWN <i>Salisbury</i>			COUNTY <i>Md.</i>	STATE
24. FUNERAL DIRECTOR NAME <i>Baker and Bowens</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>MAY 31, 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Jeanne Johnson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be attached for use on the funeral transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NOTE: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical director must initial and sign this certificate.

111725  
1



144033

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH5630  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>DAVID</b>	MIDDLE <b>Jay</b>	LAST <b>WARD, JR.</b>	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH MAY	DAY 13	YEAR 1985	2b. HOUR 0945m
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH 11 YEAR 1908	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD 5-13-85	2d. HOUR 0945m
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>906 Spring Hill Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Investment Self</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>21801</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>906 Spring Hill Road</b>			
14. FATHER'S NAME FIRST <b>David J.</b>		MIDDLE 	LAST <b>Ward</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b>		MIDDLE <b>S.</b>	LAST <b>Perdue</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>WWI</b>		16b. SOCIAL SECURITY NO. <b>Coast Guard &amp; Navy 217-03-2932</b>		17. INFORMANT <b>Albert W. Ward, Balt, Md. 21212</b>		104. ADDRESS <b>Wtrose Ave., Balt, Md. 21212</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Brain</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Acute depression. Metastatic carcinoma.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>09 30M 5-13-85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted shotgun wound.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>own home</b>		21f. LOCATION STREET <b>906 Spring Hill Rd., Salisbury, Wic. Md.</b>		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
23. TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER									
DATE SIGNED <b>5-13-85</b>									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-15-1985</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Hebron Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hebron</b>		23e. COUNTY <b>Wicomico</b>	23f. STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Baker-Bounds, Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1985</b>							
25b. REGISTRAR'S SIGNATURE <b>John L. Royer, M.D.</b>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR PERSONAL USE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

660A-1

7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

157092

REG NO. 6 3 1

FOR  
1- STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)FIRST  
NANCY

MIDDLE

LAST

2a DATE KNOWN  
OF ESTI-  
DEATH MATED  5-24-85 19  
MONTH DAY YEAR2b. HOUR  
MSEX  
Female4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
04 12 19516 AGE (IN YEARS)  
(LAST BIRTHDAY)  
34 YRS.IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN2c DATE  
PRONOUNCED  
DEAD  
MONTH DAY YEAR  
5:30P  
2d HOUR  
M7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)  
Buffalo, New York7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.8 MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH  
Wicomico County  
MD.10. CITY OR TOWN OF DEATH  
Hebron11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Rt. 1, Box 148BB Cherrywalk Rd.12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)  
Housewife

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
Wicomico13c. CITY OR TOWN  
Hebron13d INSIDE CITY LIMITS?  
YES  NO 13e. STREET ADDRESS  
Route #1 Box 148BB

21830

MD.

14. FATHER'S NAME  
James

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME  
Norma

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
No16b. SOCIAL SECURITY NO.  
100-46-170117. INFORMANT  
Mr. Gregory Weik (Husband)  
Same as #13eADDRESS  
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Multiple drug intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

2d AUTOPSY?

YES  NO 21a. EXTERNAL CAUSE WAS  
UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

P.M. 5/24 1985

ingestion of drugs

21d. INJURY OCCURRED  
WHILE  NOT WHILE   
AT WORK  AT WORK 21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

home Rt. #1 Box 148BB Cherrywalk Rd. Hebron, Md.

22a. I certify that I took charge of the remains described above, held an  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner Autopsy  Inspection  Inquiry  and in my opinion  
TITLE (SPECIFY)  
*Margarita Korell* M.D. MEDICAL EXAMINERACTUAL  
SIGNATUREDATE  
SIGNED  
5-25-85EXAMINER'S NAME  
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)23b. DATE  
5/27/198523c. NAME OF CEMETERY OR CREMATORIUM  
Salisbury Crematory23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR

NAME  
Holloway Funeral Home, P.A., Salisbury, Maryland25. DATE REC'D. BY REGISTRAR  
MAY 31 1985

125082



148088

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15632

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			John	L.	WHITE	May 18, 1985			11:30 AM					
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			Black	Month November Day 12, 1907 Year			77			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			7d. DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
VSA			VSA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			WICOMICO MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Deer's Head Center			Farming								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN							871 Box 55 21814					
Md	Wicomico	Jesterville												
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			LAST								
John O. White			Martha Brooks											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			213-16-8987			Irene White, Jesterville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Prostate c Metastasis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												(b)		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-9, 1985, to 5-18, 1985, that (I) (we) last saw the deceased alive on 5-18, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE K. Yoon, M.D. DEGREE		
22d. PHYSICIAN'S NAME		22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22f. DATE SIGNED 5-18-85						
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE			23d. LOCATION TOWN		23e. COUNTY		23f. STATE			
Burial		5/25/85		Deer's Head Center			Jesterville		Md.		MD			
24. FUNERAL DIRECTION HOME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			MAY 23 1985		Elaine Davidson				
Emerson, Bivalve, Md.														

198083

1. *Leucostoma* *luteum* (L.) Pers.  
2. *Leucostoma* *luteum* (L.) Pers.  
3. *Leucostoma* *luteum* (L.) Pers.  
4. *Leucostoma* *luteum* (L.) Pers.  
5. *Leucostoma* *luteum* (L.) Pers.  
6. *Leucostoma* *luteum* (L.) Pers.  
7. *Leucostoma* *luteum* (L.) Pers.  
8. *Leucostoma* *luteum* (L.) Pers.  
9. *Leucostoma* *luteum* (L.) Pers.  
10. *Leucostoma* *luteum* (L.) Pers.  
11. *Leucostoma* *luteum* (L.) Pers.  
12. *Leucostoma* *luteum* (L.) Pers.  
13. *Leucostoma* *luteum* (L.) Pers.  
14. *Leucostoma* *luteum* (L.) Pers.  
15. *Leucostoma* *luteum* (L.) Pers.  
16. *Leucostoma* *luteum* (L.) Pers.  
17. *Leucostoma* *luteum* (L.) Pers.  
18. *Leucostoma* *luteum* (L.) Pers.  
19. *Leucostoma* *luteum* (L.) Pers.  
20. *Leucostoma* *luteum* (L.) Pers.  
21. *Leucostoma* *luteum* (L.) Pers.  
22. *Leucostoma* *luteum* (L.) Pers.  
23. *Leucostoma* *luteum* (L.) Pers.  
24. *Leucostoma* *luteum* (L.) Pers.  
25. *Leucostoma* *luteum* (L.) Pers.  
26. *Leucostoma* *luteum* (L.) Pers.  
27. *Leucostoma* *luteum* (L.) Pers.  
28. *Leucostoma* *luteum* (L.) Pers.  
29. *Leucostoma* *luteum* (L.) Pers.  
30. *Leucostoma* *luteum* (L.) Pers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15633		
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)		LAST LOTTE			MIDDLE MAE		LAST WILLIAMS			5 - 18 - 85			2b. HOUR 1400 M	
3. SEX Female		4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR 05 27 1896			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.						
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 111 Cherry Street 21801						
14. FATHER'S NAME Joseph		15. MOTHER'S MAIDEN NAME Annie			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-07-6862		17. INFORMANT Paula Adkins (Granddaughter) 425 S. Camden Avenue, Fruitland, Md. 21826		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Peritonitis 20 to Ruptured 3 weeks Diverticulum										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-18-1985 to 5-18-1985, that (I) (we) last saw the deceased alive on 5-18-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) (did not) view the body after death.														
22b. SIGNATURE <i>M. E. Crouch</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 5-18-85						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. Crouch		22f. ADDRESS 531-5-Riverside Dr., Salisbury												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/1985			23c. NAME OF CEMETERY OR CREMATORIAL St. Andrews Church Cemetery Princess Anne, Somerset			23d. LOCATION CITY OR TOWN			23e. COUNTY Maryland			
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 21 1985			25b. REGISTRAR'S SIGNATURE June Davidson Pendell						

1  
the above that

the next of st  
and want

the  
the

the  
the

the  
the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

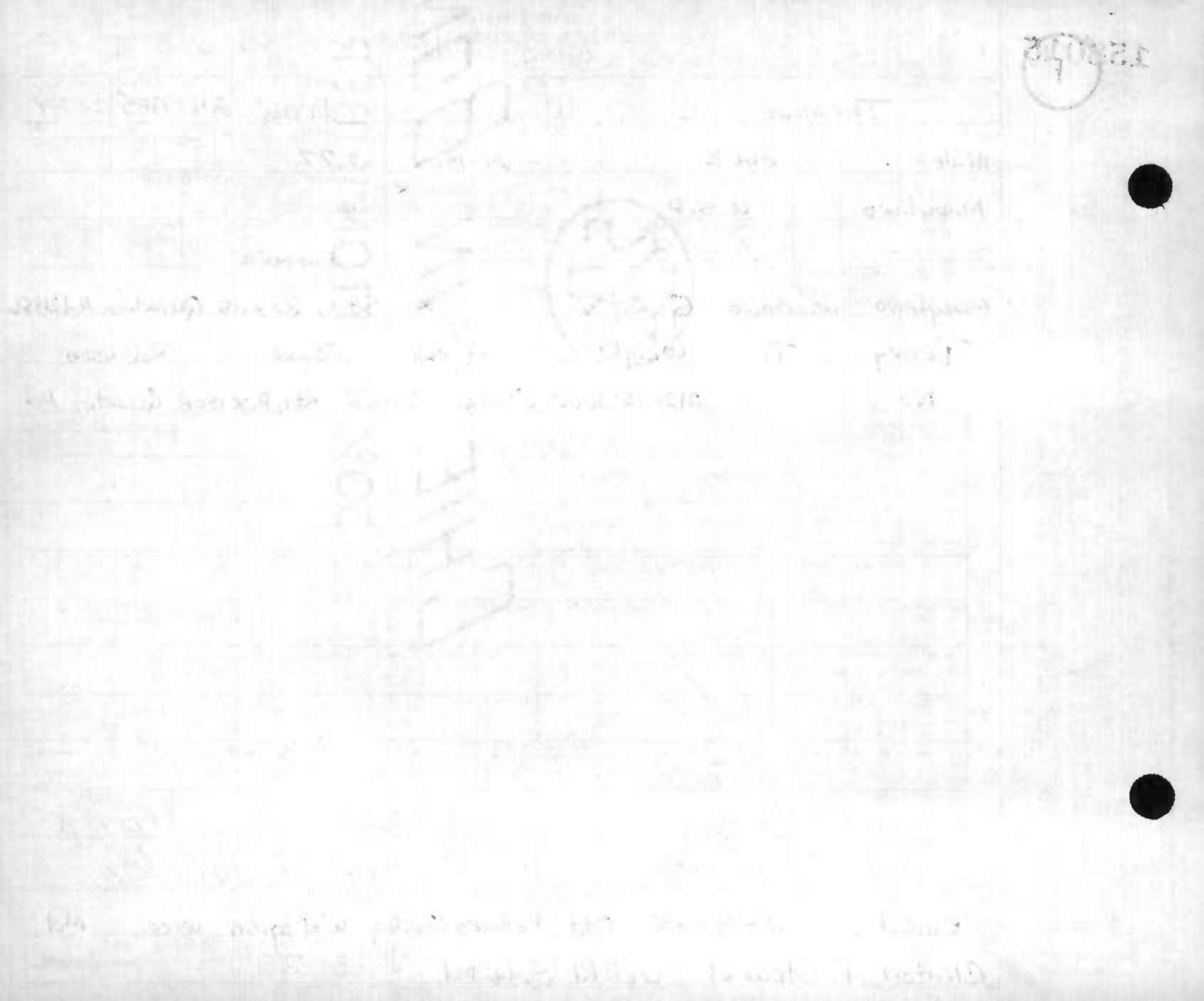
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1580195

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15634  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>Theodore C Wright</u>							<u>May</u>	<u>24</u>	<u>1985</u>	<u>20 45P.M</u>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
<u>Male</u>		<u>Black</u>		<u>1 - 24-1908</u>			<u>77</u>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
<u>Maryland</u>		<u>U.S.A</u>					<u>Wicomico</u>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<u>Salisbury</u>		<u>Peninsula General Hospital</u>					<u>Farmer</u>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<u>Maryland</u>		<u>Wicomico</u>		<u>Quantico</u>					<u>Rt 1, Box 115 Quantico Md 21856</u>				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
<u>Perry</u>		<u>T.</u>		<u>Weight</u>			<u>Sarah</u>		<u>Jane</u>		<u>Robinson</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>- Lung Cancer</u>						
No		<u>212-12-3660</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)											
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 21</u> , 19 <u>85</u> to <u>May 24</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> , 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Paul R Fleury</u>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED <u>5/24/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAUL R Fleury</u>		22e. ADDRESS <u>540 Riverspr Dr Salisbury</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-28-85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Odd Fellows Cemetery Wetumpkin Co.</u>		23d. LOCATION CITY OR TOWN <u>Wetumpkin</u>		COUNTY <u>W.C.O.</u>		STATE <u>MD</u>			
24. FUNERAL DIRECTOR NAME <u>Clinton F. Stewart</u>		ADDRESS <u>1007 Rd. Salisbury Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Clinton F. Stewart</u>							
DHMH - 16 60M 7/84 (VRA 15, 4)													

240225



HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached by the hospital or attending physician.

30 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15635			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
JOHN R YOGGERST						May 17 1985					0251 AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 2-17-27			6. AGE (IN YEARS LAST BIRTHDAY) 58			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DEL.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD.	
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTENDER			12b. KIND OF BUSINESS OR INDUSTRY SERVICE				
13a. STATE DEL			13b. COUNTY SUSSEX			13c. CITY OR TOWN SEBYVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 33 F LAWS PT. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY MIDDLE YOGGERST			15. MOTHER'S MAIDEN NAME MARY SAME YOGGERST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW 351-18-5452			17. INFORMANT M. SMITH			ADDRESS SEBYVILLE, DEL.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC PULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK													
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that ( ) (this hospital) attended the deceased from 5/15/85 to 5/17/85, that if (we) lost sow the deceased alive on 5/17/85 and that in ( ) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) did ( ) view the body after death.													
22b. SIGNATURE Dr. Koenrich M.D.			DEGREE			22c. DATE SIGNED 5/17/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-20-85			23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA			23d. LOCATION CITY/TOWN COUNTY LEWES SUSSEX, DEL.				
24. FUNERAL DIRECTOR NAME ULRICH F.H. BERLIN, MD.			ADDRESS			25a. DATE RECD. BY REGISTRAR MAY 28 1985			25b. REGISTRAR'S SIGNATURE Handwritten Signature				

1000

